MEDICARE PART B CARRIER ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MARCH 5, 1990

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MEDICARE PART B CARRIER ISSUES

MONDAY, MARCH 5, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Atlanta, GA.

The subcommittee met, pursuant to notice, at 1:30 p.m. in the Georgia Supreme Court Courtroom, Sixth Floor, Judicial Building, 40 Capitol Square, Atlanta, GA, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

The subcommittee is meeting this afternoon to hear testimony regarding the administration of part B of the Medicare program.

All too frequently, we spend the bulk of our time examining policy issues and making changes in the legislative policies governing the program, while not paying adequate attention to how these policies are implemented. We often have an incomplete understanding of the practical effects on patients and health care providers.

Today, we have an opportunity to review the part B claims review procedures. The timing and location of this particular hearing is prompted by the vocal concerns expressed by patients and physicians throughout Georgia regarding delays and errors in the review and resolution of claims for physician services. Attention has focused on the fact that there was a transfer of the carrier function at the beginning of 1989, as well as the pilot project involving a subcontract with a separate, private sector organization for medical review. These may or may not turn out to be important matters for the subcommittee's consideration.

The principal concerns of the subcommittee deal with the general and systemic issues that are raised by this experience. What does it tell us, by way of example: About the oversight and management of the program? About the respective roles and responsibilities of the various agencies? About the development and implementation of medical review criteria? About whether we are devoting sufficient resources to administering the program? About whether the administration of the program in its entirety is promoting or impeding the delivery of quality care?

Most importantly, what does it tell us about whether the program is meeting the need of its beneficiaries?

Unfortunately, we are not able to accommodate all the individuals and groups who wished to testify here today. We do have those agencies and organizations that have been most intimately in-

volved in these issues here in Georgia. Others will be submitting written material for the hearing record and I want to assure them that they will be carefully considered by the subcommittee.

The issues being raised here are neither local nor transitory. I expect that this hearing will not exhaust the subcommittee's interest in the subject.

Before calling on our witnesses, I want to recognize the very distinguished member of our subcommittee and the gentleman who has called us here to this hearing in Georgia, Dr. Roy Rowland.

Mr. ROWLAND. Mr. Chairman, thank you very much, and I wish to express to you personally my sincere appreciation for you coming here today, and also on behalf of the people of the State of Georgia, I also express that appreciation. I thank the members of the staff who have worked on this, my staff and the staff of the Health and Environment Subcommittee. I appreciate all the witnesses coming, particularly my colleagues here in the Georgia delegation, and to the judiciary for providing this facility to us.

Mr. Chairman, I do not know how many providers and patients there are out there that are having problems. I hope we will be able to learn something about that today. But I do know there has been a lot of turmoil in our State this past year in the Medicare reimbursement area, or else I would not be hearing all of the things that I have heard.

I have heard from so many physicians and other people—a meeting was held in Savannah last year on this with over 200 in attendance. There have also been other meetings around the State. At town meetings that I have had, there have been patients—I refer to them as patients, I still almost think of myself as a doctor although I am not in practice now, but constituents who have come to those town meetings and talked about the problems that they have had in getting reimbursed for their Medicare claims.

Mr. Chairman, there must be something wrong, or else we would not be hearing from so many people. I hope that today we can find out what is wrong. I hope we can find what is really the root problem of the difficulty that we have been hearing about this past year.

I really hope that this hearing is going to focus on that, that this will just not be a hearing where we hear people complain about what is going on and hear the other side saying well there is really no problem, everything is all right. I hope that we can really get to the substance of what is taking place. People do not need to be in an adversary situation with one another particularly when it comes to the health care of the people here in our State and our country.

So I just really appreciate you being here and hope that we can really get to the root cause of this problem. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Rowland follows:]

OPENING STATEMENT OF J. ROY ROWLAND

Mr. Chairman: physicians and patients throughout Georgia are angry, frustrated and more than a little bewildered over the way their Medicare claims have been handled for the past 14 months.

The problems began when HCFA selected a new part B Medicare carrier for Georgia in January 1989, and the State became a guinea pig for an experimental oversight program.

Transition problems are expected. But in Georgia, complaints of delays, improper downgrading and denial of claims, and difficulties in appealing even the most obvious mishandling of claims have been overwhelming. Georgia faces threats of lawsuits, the withdrawal of physicians from Medicare participation, and patients foregoing medical care because of the uncertainty over reimbursements. Medicare is literally in turmoil.

Those responsible have, in fact, often tried to be helpful. Aetna has improved its procedures, eliminating a big backlog. HCFA and HealthCare COMPARE have been responsive when called upon. Nevertheless, claims that appear to be legitimate continue to be reduced or denied.

Inquiries into Georgia's Medicare problems have been launched by GAO and the Inspector General's Office of the Department of Health and Human Services. Georgians need answers now, however. That's the purpose of this hearing—to learn the scope of the problems; the causes and the solutions; and impact of the oversight program; and most of all, how to reestablish a measure of trust between patients, health care professionals and the Medicare system.

Every member of the Georgia congressional delegation has been working on the problem, and this teamwork has been invaluable. Health and Human Services Secretary Louis Sullivan has certainly been helpful. The Georgia media should also be commended for its thorough and probing coverage of this issue.

Mr. Chairman, on behalf of everyone in Georgia, I want to express our special thanks to you. Although the subcommittee, and you personally, are confronted with a very busy agenda this year, you are nevertheless devoting time and energy to Georgia. Hopefully, what we learn here will benefit not only our State, but all States facing similar problems in the future.

Mr. WAXMAN. Thank you very much, Dr. Rowland. I am pleased that we have four of our colleagues that represent this State so ably in the Congress of the United States willing to take of their time to make a presentation before the subcommittee, and I would like to call on each of them beginning with the Honorable Lindsay Thomas.

Mr. THOMAS. Mr. Chairman, thank you very much. It was my understanding perhaps that I would be last in testimony, but I certainly am——

Mr. WAXMAN. We can start at the other side.

Mr. THOMAS. Well I think that was sort of planned, if that is acceptable to my colleagues.

Mr. WAXMAN. Congressman Darden.

STATEMENT OF HON. GEORGE (BUDDY) DARDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DARDEN. Thank you very much, Mr. Chairman. Some people say the last shall be first and the first shall be last. I am delighted to be the first witness here today.

I think it is particularly appropriate, Mr. Chairman, that you have chosen this particular location. As a young lawyer in the State of Georgia and as a district attorney, I litigated in this room a number of times, and I always was able to obtain in this room what I thought was a satisfactory resolution to many problems in our legal system and I think it is very appropriate that we are here today in the Supreme Court chambers, and thank you for choosing this particular location.

Also Mr. Chairman, I want to thank you and I cannot overemphasize the importance of your coming down here, together with our colleague, Dr. Rowland, to hold this hearing. I think the mere fact that you have seen fit to come to this location, to call this

hearing, and as you and Dr. Rowland have expressed this interest in our problem shows that you are concerned and you are caring about one of the most serious problems that we have encountered and certainly I have encountered since I have been a member of Congress since 1983.

I am here today to reiterate the concerns of the people of the Seventh District of Georgia, which is located just to the northwest of us here today. I emphasize "reiterate" because the outcry of my fellow Georgians is one that we have all been hearing, loud and strong, for more than a year now. The voice of the media has certainly been helpful to us as well, but we sense something is very wrong in our health care delivery system, in Medicare, in this State.

Mr. Chairman, when the health care providers and the hospitals, the physicians and the Medicare beneficiaries all agree that the system is not working, I think this shows us that we have reached a point that drastic action needs to be taken.

Over the past year, I have received hundreds of complaints from Medicare patients regarding slow service, lost claims and unexplained denials. Let me bring your attention to just one situation of an 89-year-old man who resides in Georgia's 7th district. He has been waiting for adequate reimbursement from Aetna for more than a year. His bill for treatment for pneumonia and plastic surgery for third-degree burns to his head, arm and leg totals more than $2,500. To this date, this man has received a check for only $639 and a refusal from Aetna to pay any more on this claim. His family has scheduled a hearing in the hopes that this man may receive additional reimbursement. I find situations such as this to occur very often and there have been many, many others.

In my opinion, Mr. Chairman, prompt and adequate reimbursement is critical for those living on a fixed income. I know of no way to successfully stretch a stationary salary. Of course, there is the frustration caused by month-long periods of waiting and having to resubmit claims over and over again, but the real danger lies in our citizens delaying medical care for fear of reimbursement troubles. It is our responsibility as a Congress to see that we do all we can to ensure that this trend does not continue.

Our physicians, Mr. Chairman, I might say are equally disenchanted with the system and many of them tell me now that they would rather treat a patient at no cost rather than go through the indignities or the denials that they have had over and over again from Medicare.

Mr. Chairman, I will not take away from the time of the people who will testify here today, and my colleagues, except to say I hope that we can find some answers here today. I thank you again for your coming down and giving your personal attention to this. We are very proud to have Dr. Rowland as a member of your subcommittee as well, and we appreciate his attention.

I ask also that my statement in its entirety be included in the record.

Mr. WAXMAN. Thank you very much. Without objection, all the statements will be entered into the record in their entirety.

Any particular order you gentlemen want to proceed? Mr. Ray.

[The prepared statement of Mr. Darden follows:]

Prepared Statement of Hon. George (Buddy) Darden

Chairman Waxman: I am here today to reiterate the concerns of the people of the 7th district of the State of Georgia regarding Medicare. I emphasize "reiterate" because the outcry of my fellow Georgians is one that we all have been hearing—loud and strong—for more than a year. Through the voice of the media and contact with their elected representatives and State authorities, Georgia's physicians and Medicare beneficiaries are demanding improvements in our Medicare system. Please let me convey their concerns to you.

Aetna Life and Casualty Insurance Co. of Savannah inherited a backlog of 800,000 claims when it became administrator of Medicare reimbursements for the State of Georgia in January 1989. Understandably, there were to be some processing complications given the enormous workload. Additionally, the former Medicare carrier, Prudential, used its Medicare office in Georgia to process private health insurance claims and left no experienced staff to hire. I understand this situation required much renovation work to an office building in Savannah, and the hiring and training for 330 processing positions. This was undoubtedly a great challenge to meet. However, it has been more than a year since the transition, and Aetna still is not performing at an acceptable level.

Over the past year, I have received hundreds of complaints from Medicare patients regarding slow service, lost claims and inexplicable denials. Let me bring to your attention the case of an 89-year-old man who resides in Georgia's 7th district. He has been waiting for adequate reimbursement from Aetna for more than a year. His bill for treatment for pneumonia and plastic surgery for third-degree burns to his head, arm and leg totals more than $2,500. To date, this man has received a check for only $639, and a refusal from Aetna to pay any more on this claim. His family has scheduled a hearing in hopes that this man may receive additional reimbursement. I find situations such as this, and there have been many others, tragic.

Prompt and adequate reimbursement is critical for those living on a fixed income; I know of no way to successfully stretch a stationary salary. Of course, there is the frustration caused by month-long periods of waiting or having to resubmit claims, but the real danger lies in our citizens delaying medical care for fear of reimbursement troubles. It is our responsibility that we do all we can to ensure this trend does not happen.

Physicians, also, have loudly voiced their complaints to me regarding Aetna, and more specifically about HealthCare COMPARE Corp. of Chicago. The Health Care Financing Administration, which oversees Medicare, requested Aetna to hire a private claims reviewer as part of a test aimed at stemming physician abuse of the Medicare system, as well as to help handle the backlog of claims. However, these physicians have complained that HealthCare CONPARE is arbitrarily downgrading claims rather than focusing on a select few who choose to take advantage of the system. Responsible physicians should not suffer because of poorly designed rules and regulations. I strongly suggest we investigate alternative methods for claims processing.

Setting aside the technical complications of operations, Medical Association of Georgia President Joe Nettles brought to my attention Aetna's apathetic attitude regarding the 20-percent blunder. In this instance, Aetna had reduced clinical laboratory charges to all physicians, by some 18 percent—deducting 20 percent rather than 2.092 percent. This was done in order to achieve the Gramm-Rudman-Hollings deficit reduction requirement. This mistake continued over a 30-day period. No attempts were made to communicate this problem to the physician community or to provide a reasonable solution. The physicians who detected the effort and contacted Aetna were told to conduct their own claim investigation, and resubmit previous charges for corrected reimbursement. Although this is a blatant ineptitude, it also portrays Aetna to be indifferent to the needs and desires of Georgia's medical community.

Recent reports from Aetna, HealthCare COMPARE, and the Health Care Financing Administration indicate that some progress has been made since approximately 3,000 people jammed phonelines with complaints in a 2-day telephone hotline made possible by the Atlanta Journal-Constitution in November 1989. I want nothing more than conclusive evidence that this is true—that we are well on our way toward solving this year-long predicament. As HealthCare is one of the most pressing concerns in our Nation today, it deserves a commitment from all of us. We simply cannot afford to fall behind any longer.

STATEMENT OF HON. RICHARD RAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. RAY. Chairman Waxman and Congressman Rowland, it is a real pleasure to be here today with you, and I do want to tell you how much I appreciate you having this hearing here in Atlanta. I would like to join my colleague, Mr. Darden, also in saying how proud we are that we have—of course, Dr. Rowland was one doctor in the Congress for awhile and now we have two, the only one I know is him because I rely on him very heavily for whatever concern that we have about Medicare and health bills that he is interested in, and he normally gets my vote without any reservation. I have the highest confidence in him and am very grateful that he is here today and on the committee.

I am going to submit a good bit of my statement for the record. I also would ask that about six or seven statements from individuals who have concerns be entered into the record, Mr. Chairman.

Mr. Chairman and Congressman Rowland, since the Medicare part B carrier in Georgia has changed from Prudential to Aetna in early 1989, my office has been called on to assist a great number of citizens from the 3rd congressional district, who have had difficulties with receiving Medicare payments. Presently I have about 60 pending requests—cases in my file, about 15 or 20 are coming each month. Many of these people have experienced delays of over 5 months. This type of delay has often led to severe financial hardships.

Let me say at this time that I do not want to really criticize the Aetna Co. because they came in with a severe backlog. The Prudential Co. used one coding type system to file claims, Aetna has been forced to change to another coding system. Many doctors get these codes mixed up and the claims just actually come back to the doctor or to the recipient in many cases. If a recipient does not have a doctor or someone to file the claim, the recipient attempts to file the claim themselves and it sometimes never comes back.

One example is a constituent who had surgery on both of his feet. The cost of the surgery was $2,086. The insurance company approved $1,177 and paid 80 percent of that amount which is $941. The constituent asked for a review of his claim in November, but it has still not been reviewed.

When my office contacted the insurance company, we were told that the rule is to pay for only one foot, with half payment for the other foot. If he had surgery on one foot at a time, Medicare would have paid twice, including the anesthesiologist. By having surgery on both feet at once, the anesthesiologist was paid only once, so the constituent saved money by having one operation, yet Medicare paid him a lot less and he had to get the money out of his pocket. Unfortunately, the constituent did not have the money to pay the difference in this particular case.

Another case involves a 70-year-old woman who had her stomach removed in 1982 due to cancer. She receives food through a tube. Nutritional supplies and a machine have been provided by a home health care agency. Her husband is 78 years old and takes care of her, which is a tremendous responsibility.

In the past, Medicare always paid for her machine and supplies without any problem. Her physician periodically updates the required Medicare forms for her to continue to receive payment. In answering the questionnaire, her doctor indicated that nutritional supplies were not her only source of food intake, because periodically her husband could scramble her an egg and she could eat just a little bit of that egg, and he thought this was good to try to keep her faculties going and the fact that it would give her a little something to depend on other than that food intake—just maybe once or twice a week he would do this.

Now the insurance company denied the payment of the claim, which is about $860 a month, because the doctor indicated that she had an additional source of food intake. Now we understand how this could happen on a form type situation. This situation has now been resolved, but it created a severe shortage of funds and problems for the people while it was being resolved.

Another constituent had surgery costing $1,700. Medicare approved $528, paid 80 percent or $422. The constituent had to pay the balance, which was about $1,300. The insurance company said that the $528 is correct and the doctor is correct in charging $1,700 which is the maximum allowable charge. Obviously the doctor and the insurance company disagree as to how much that surgery is worth. Many times this is the only insurance the people have and they have no other income other than just a little bit of Social Security.

Now let me just jump over a little bit. I have several instances that I want to submit for the record, but let me jump over on the side of the doctor for just a little bit.

The doctor operates a business and in order to keep it open, he or she has to have some money coming in to take care of the overhead. I had a meeting just about 2 weeks ago where 30 doctors came in with HCFA, with HealthCare COMPARE, with the insurance company and with the Medical Association of Georgia. A doctor says that he would normally get $28 for an office visit, just a routine office visit, Medicare will pay $20. He sends a claim in, because the number does not correspond or some little problem that does not meet the criteria, it comes back, he pays a nurse in the office who gets $10 an hour to spend a little time trying to find out what is wrong, it takes $11 worth of her time to do so—he throws the claim in the trash can because it does not pay to send it back and maybe get it turned down one more time. Much of this is occurring, according to many of the doctors.

In my opinion, there is a dangerous trend, given the fact that the fastest growing segment of our population is people in their eighties now. Half the people who have ever lived in this world, I am told, to be 60 years old, are living right now.

It is apparent that doctors are dissatisfied with the way they are being treated by the insurance company and particularly with HealthCare COMPARE. One very prominent physician got on his feet and said that the former insurance company, without HealthCare COMPARE, got along reasonably well. But when HealthCare COMPARE came into the picture, everything began to slow down and get into some serious problems. So he thinks that we need to do away with HealthCare COMPARE.

The use of HealthCare COMPARE is what physicians have been most concerned about. They have characterized this organization as arrogant—coming from the doctors themselves. And I will have to say that I understand there are about 35 doctors running HealthCare COMPARE and I raise a question that maybe because they are doctors is why they are so arrogant—I say that in jest of course. In fact, many doctors have become fed up with Medicare and are indicating that they do not want Medicare patients any more.

I asked the 30 doctors in the room how many are currently taking Medicare assignments. Only 10 said that they were. I asked the remaining 20 doctors would they continue to take Medicare assignments and only 2 said that they were going to continue in the future.

So this is unfortunate and unnecessary, in my opinion. When we have this type of bureaucratic red tape in Medicare, it is ultimately the Medicare recipients who are hurt. They are sometimes forced to change doctors or file all the Medicare paperwork themselves. The Medicare patient just wants to get well, like everybody else who is ill. They do not want to worry about whether Medicare will pay for a physician visit or medical procedure, and they do not want to be sued by a collection agency when it does not come through.

Just to summarize, we have a bad situation here in Georgia. I believe that HealthCare COMPARE is adding to that. I am hopeful that it will improve. I know that there are a number of dedicated people who are working to resolve the problems with the Medicare system. I know this committee is concerned about it and I am grateful for that. And I also believe that this hearing will help in correcting, or at least focusing some attention on this situation.

Again, I want to tell you and Dr. Rowland and your capable staff how much I appreciate you being here.

Mr. WAXMAN. Thank you very much, Congressman Ray.

[Testimony resumes on p. 33.]

[The prepared statement and attachments of Mr. Ray follow:]

PREPARED STATEMENT OF HON. RICHARD RAY

Mr. Chairman and Congressman Rowland, I appreciate the opportunity to testify this afternoon regarding the problems which have occurred in Georgia with reimbursement for services provided under part B of the Medicare Program.

Since the Medicare part B carrier in Georgia was changed from Prudential to Aetna in early 1989, my office has been called on to assist over 60 citizens from the third district who have had difficulties with receiving Medicare payments. Many of these people have experienced delays of over 5 months. This type of delay has often led to severe financial hardships.

One example is a constituent who had surgery on both of his feet. The cost of the surgery was $2,086, and Aetna approved $1,177 and paid 80 percent of that amount which is $941. The constituent asked for a review of his claim in November, but it has still not been reviewed.

When my office contacted Aetna, we were told that the rule is to only pay for one foot, with half payment for the other foot. If he had surgery on one foot at a time, Medicare would have paid twice, including the anesthesiologist. By having surgery on both feet at once, the anesthesiologist was paid only once. So the constituent saved money by having only one operation, yet Medicare pays him less. Aetna's reasoning on this does not make sense to me.

Another case involved a 70-year-old woman who had her stomach removed in 1982 due to cancer. She receives food through a tube, and nutritional supplies and a ma-

chine are provided by a home health care agency. Her husband is 78 years old and takes care of her which is a tremendous responsibility.

In the past Medicare always paid for her machine and supplies without any problem. Her physician periodically updates the required Medicare forms for her to continue to receive payments. In answering the questionnaire, her doctor indicated that nutritional supplies were not her only source of food intake. This is true because her husband tries to stimulate her taste and chewing abilities by scrambling an egg for her on occasion. She is only able to swallow one-fourth to one-third of the egg before it becomes too difficult, and she has to stop.

Aetna denied the payment of the woman's claim, which is about $860 a month, because the doctor indicated that she had an additional source of food intake. Fortunately, this situation has been resolved. However, the denial of the claims created a great deal of stress for this couple. They are a very devoted couple, and the wife would rather starve than create a problem for her husband. In fact, her husband was willing to borrow money to pay for his wife to be fed.

One other constituent had surgery costing $1,700. Medicare approved $528 and paid 80 percent or $422. The constituent had to pay the balance which was almost $1,300. Aetna says that the $528 is correct and that the doctor is correct in charging $1,700 which is the maximum allowable charge. Obviously, the doctor and Aetna disagree as to how much that surgery is worth. These amounts should be much closer together.

The constituent who incurred this charge has been trying to get this claim reviewed for over a year. In the meantime, a collection agency has been seeking money from her.

These are just some examples of problems which are happening in the third district. Patients just want to get well. They don't need their problems compounded by the Medicare bureaucracy. Of course, the frustrations with Medicare reimbursement are affecting the doctors also.

A doctor operates a business, and in order to keep it open he or she has to have money coming in. Delays in processing claims, and the denial and downcoding of claims, is destroying the motivation of doctors to receive Medicare patients. This is a dangerous trend given the fact that the fastest growing segment of our population is people in their eighties.

I recently held a meeting in one of my district offices with a group of about 25 physicians to discuss their concerns with reimbursement. The meeting was also attended by representatives from Aetna, HealthCare COMPARE, the Healthcare Financing Administration, and the Medical Association of Georgia.

It is apparent that doctors are dissatisfied with the way they are being treated by Aetna and HealthCare COMPARE. Their problems with reimbursement did not being until the Medicare part B carrier in Georgia was changed from Prudential to Aetna in early 1989.

The use of HealthCare COMPARE is what physicians have been most concerned about. They have characterized this organization as "arrogant," and "incompetent," among other things. In fact, many doctors have become fed up with Medicare and are indicating that they do not want Medicare patients anymore.

This is unfortunate and unnecessary in my opinion. When we have this type of bureaucratic red tape in Medicare, it is ultimately the Medicare recipients who are hurt. They are sometimes forced to change doctors or file all the Medicare paperwork themselves. The Medicare patient just wants to get well, like anyone else who is ill. They do not want to worry about whether Medicare will pay for a physician visit or medical procedure.

To summarize, we have a bad situation here in Georgia. I am hopeful it will improve, and I know there are a number of dedicated people who are working to resolve the problems with the Medicare system. I also believe this hearing will help in correcting the situation.

Once again, I want to thank you for holding this hearing today and providing me an opportunity to speak to you.

Case of:

Mr. Tom Lindsay

He is dissatisfied with amount paid by Medicare for surgery on 8-22-89 by Dr. Funk

Medicare approved only $1177.05, paid 80% = $941.64 of the $2,086.00 claim.

He thinks charge was reasonable for surgery on both feet.

He asked for a review on 11-13-89

Our office contacted Medicare and was told that the rule is only pay on one foot, and half on the other..

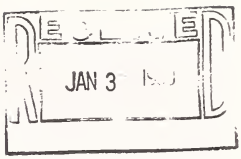
He could have had one foot done, and gone later for the second one, and Medicare would have paid twice. This would mean that the Anesthesiologist would have to be paid twice also.

Doing both feet at once, the anesthesiologist was paid once.

This is still pending. Trying to get it reviewed.

THOMAS W. LINDSAY

12-31-89



Richard Ray, Congressman
Courthouse Annex
Warner Robins, Ga 31088

Dear Sir:

This is to ask your help in resolving a claim I have with Aetna Medicare in Savannah, Ga.

On Aug 22, 1989 Dr. Trunk performed an operation on my foot. His charge was $2086.00 which I thought was reasonable. On Oct 24, 1989 Aetna paid 941.64 against an approved amount of 1177.05. On Nov 13, 1989 I appealed this decision by asking for a review - attn: Louis. To date I have not heard from this review.

My health insurance claim # is 428-18-9676A. I would appreciate your interest in this matter.

Sincerely,

Thomas W. Lindsay Jr

[redacted]

Still in review process
30 days - K

Case of:

Elizabeth D. Burrell [redacted]

She asked our office for help on 1-3-90

Re: excessive charges or loss Medicare payment on her surgery claim, of 2-14-89

Charge $1700.00
Medicare approved $528.40 paid 80%, which is $422.72

Dr. was not assigned so this left patient with a huge difference to pay.

The Dr. had told her not to worry about it, not get second opinion, as he would take care of balance....Medicare did not pay as well as the thought, so he charged the remaining to her and she is liable as he is not assigned.

Medicare says the $528.40 is correct, and the $1700.00 is correct for Dr. Zweig as his MAX

There is too much difference in the amounts of which Dr. Zweig thinks his surgery is worth, and just what Medicare thinks the surgery is worth. They need to get closer together here.

Medicare patients cannot afford such a difference, as most are on SS benefits.

They are asking for a review. This has been going on for over a year now. The Dr. is turning his over to collection agency to collect from Mrs. Burrell.

[redacted]
January 11, 1990

The Honorable Richard Ray
200 Carl Vinson Parkway
Warner Robbins, Georgia 31088

RE: Elizabeth D. Burrell [redacted]
Medicare Claim Control Nos.:
[redacted] (dated March 29, 1989)
[redacted] (dated June 22, 1989)

Dear Sir:

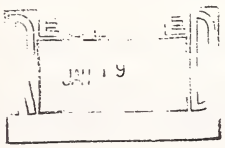
I am requesting your office inquire into the medical charges approved by Medicare on the above claims to help me determine if the charges were excessive or if Aetna Medicare failed to approve an equitable amount for such medical charges in the Atlanta area.

On February 14, 1989, Dr. Arnold Zweig of E.E.N.T. Assoc. of Atlanta performed surgery to remove a stone from my saliva gland. Although Dr. Zweig is not one of Medicare's assigned doctors, he and his office assured me prior to the surgery that the charges would be covered by Medicare and that a second opinion was not needed. I entered Georgia Baptist Hospital on February 13, 1989 and was dismissed February 15, 1989.

Dr. Zweig's charge of $1,700 was submitted to Medicare. On March 29, 1989, Medicare misread the charge as $17 and approved $13.60. This claim was appealed through the Griffin, Georgia Medicare Office and on June 22, 1989, Medicare approved $528.40 of the $1,700 charge.

I have received no cooperation from Dr. Zweig's office for more information to make a second appeal, and his office has denied that he agreed to accept the Medicare approved charges for the surgery. On December 13, 1989, I received notice that the $1,171.29 balance had been turned over to Medical Business Bureau, Inc. for collection. I have informed their office that the balance is in dispute; however, they may proceed for a judgment against me for collection.

I am enclosing copies of the March 29, 1989 and June 22, 1989 Medicare approval forms. I would appreciate any help you and your office can give me in this matter.



JAN 22 1990

Very truly yours,

Elizabeth D. Burrell

Elizabeth D. Burrell

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

GA-U-007815

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
12052 MIDDLEGROUND RD
P.O. BOX 3018
SAVANNAH, GA 31402

JUNE 22, 1989

HAVE MEDICARE QUESTIONS? CONTACT:
(912) 927-2412 OR TOLL
FREE 1-800-727-0827.

ELIZABETH D BURRELL
[redacted]

JUR HEALTH INSURANCE CLAIM NUMBER
[redacted]

JUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING 1700.00. (SEE ITEM 4 ON BACK).

\RTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE .AIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANTION OF ASSIGNMENT. WRITE ? CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE IST OF PARTICIPATING DOCTORS AND SUPPLIERS.

		BILLED	APPROVED
? ZWEIG			
-SURGERY	FEB 14,1989	$ 1700.00	$ 528.40
PPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.			

)TAL APPROVED AMOUNT	$ 528.40
EDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)	$ 422.72
MEDICARE PAYMENT INCLUDING INTEREST	$ 423.03

YOUR PAYMENT INCLUDES INTEREST SINCE WE WERE UNABLE TO PROCESS YOUR CLAIM TIMELY.

EMARKS:

THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM AND REFLECTS CORRECTED PROCESSING.

THIS REPRESENTS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM. IF AN UNDERPAYMENT WAS MADE, AN ATTACHED CHECK REIMBURSES THE TOTAL CLAIM ALLOWED AMOUNT MINUS THE AMOUNT ORIGINALLY PAID. IF AN OVERPAYMENT REQUIRING A REFUND WAS MADE AND A REFUND HAS NOT ALREADY BEEN SUBMITTED, YOU WILL BE CONTACTED BY LETTER FROM THE MEDICARE CLAIMS OFFICE.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

GA-U-007816

HEALTH CARE FINANCING ADMINISTRATION

Copy

THIS CONTINUES EXPLAINING BENEFITS ON CLAIM CONTROL NUMBER - [redacted]
FOR HEALTH INSURANCE CLAIM NUMBER - [redacted]

YOU ARE RESPONSIBLE FOR A TOTAL OF $ 1277.28, THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE MEDICARE PAYMENT. YOU COULD HAVE AVOIDED PAYING $ 1171.60, THE DIFFERENCE BETWEEN THE BILLED AND APPROVED AMOUNTS, IF THE CLAIM HAD BEEN ASSIGNED.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET THE DEDUCTIBLE FOR 1989.) THE DATE AT THE TOP OF THIS EXPLANATION OF MEDICARE BENEFITS IS NOT ALWAYS THE DATE THE DEDUCTIBLE WAS APPLIED.

IMPORTANT IF YOU DO NOT AGREE WITH THE AMOUNTS APPROVED YOU MAY ASK FOR A REVIEW. TO DO THIS YOU MUST WRITE TO US BEFORE DEC 22 1989. (SEE ITEM 1 ON THE BACK.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, CONTACT US IMMEDIATELY. ALWAYS GIVE US THE:

MEDICARE CLAIM NO. [redacted] CLAIM CONTROL NO. [redacted]

Case of:

B. Bronson Stubbs
[redacted]

Mr. Stubbs called us and wrote ror help. (1-25-90)
He is a dialysis patient. He is a home patient and does his own. His problem is with HCFA - through Medicare stating that will only pay for supplies through one place. His medication comes from 2 different places, and is established to be best for him. This office has contacted Health & Human Resourses in Baltimore with his case. He is a Method II , and Medicare wants to only use one supplier - and suppliers do not always carry all the medication that you are use to using.

People respond to medications differently, and the best has to be selected.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

December 14, 1989

Dear Medicare Beneficiary:

(NOTE: If you do not dialyze at home this letter does not apply to you–please discard it.)*

New requirements for people who dialyze at home have been recently enacted. We want to explain these changes and the choices now available to you. Most importantly, we want to assure you that payment for your dialysis treatment will continue.

Medicare can help pay for the cost of home dialysis in two ways:

Method I You obtain your equipment and supplies from a Medicare approved dialysis facility.
Method II You obtain your equipment and supplies directly from a supplier.

Changes in the Law

If you use Method I, the new law will not change how Medicare helps pay for your care.

The new changes only apply if you use Method II. Beginning on February 1, 1990:

1. There will be a limit on the amount that your supplier may be paid for home dialysis supplies and equipment.

2. You will need to get all your home dialysis supplies and equipment from one supplier.

3. All suppliers must accept Medicare assignment, which means that they must accept Medicare's allowed charge as payment in full.

Your particular supplier may continue to furnish home dialysis supplies and equipment under the new law. If your supplier decides to continue and you do not wish to change suppliers, you may continue with that supplier. Your supplier will explain the new requirements and your responsibilities to you. If your supplier decides not to provide home dialysis supplies and equipment or you wish to change, you have the following choices:

1. Choose a new supplier for Method II

   Of course, your new supplier must meet all the requirements of the new Medicare law. The new supplier will explain these requirements and your responsibilities to you.

NOTE: If you are receiving staff-assisted home dialysis from a supplier, your supplier may continue to provide a free staff assistant under the new statute, but may choose not to because of the changes in payment. Therefore, if you wish to continue to have dialysis in your home and you have not received self-dialysis training, you will need training. Medicare will pay to train you and another person (a relative, friend or neighbor, for example) to assist you. You may also wish to ask your State Health Department if it can help pay for a home dialysis staff-assistant.

2. Choose home dialysis using Method I

You may stay at home and have a dialysis facility furnish your equipment and supplies. These facilities must accept assignment which means they must accept Medicare's allowed charge as payment in full.

NOTE: If you do choose to stay at home and arrange for a facility to furnish your equipment and supplies under Method I, you must notify Medicare. The dialysis facility you choose will help you do this. Medicare must receive the notice by May 31, 1990, or your change will not take effect until January 1, 1991.

3. Choose facility dialysis

While Medicare encourages beneficiaries to dialyze at home, you may always choose to receive dialysis in the dialysis facility of your choice. You may begin treatment there as soon as you make arrangements with the facility. There are no forms to fill out and no waiting periods.

Assistance from Medicare

If you need help in understanding your choices or finding a new supplier or a dialysis facility, the Medicare regional office in your area will help you. The regional office will help you contact your local ESRD Network representative or help arrange for home training for you and an assistant. The person and telephone number to call are Doug Marshall, 404-331-0100.

Sincerely,

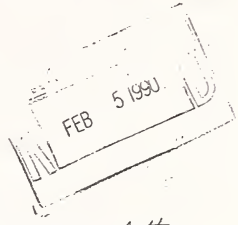
Kathleen A. Buto

Kathleen A. Buto
Acting Director
Bureau of Policy Development

[redacted]

January 25, 1990

Honorable Richard Ray
U.S. House of Representatives
Washington, D.C. 20510



Dear Mr. Ray,

I am enclosing a copy of a Dec. 14, 1989, letter I received from HCFA regarding changes in reimbursement for Method II home dialysis. Also enclosed is a letter of response from me on that change plus another subject of concern to me involving Medicare reimbursement rules.

Method II reimburses directly supplies (at 80%) only for supplies and equipment (i.e., rental, usually, unless the equipment is purchased) as required by the patient. (I use Method II and reorder supplies every 6-8 weeks.) Method I reimburses a dialysis facility (at 80% also I think) but at the rate of about $110-120 per treatment for a home patient, and the dialysis center looks after ordering the supplies and paying the rental for equipment (or otherwise providing the equipment) for the patient.

I think Method I costs the government (Medicare) considerably more (perhaps 100% more) if the patient uses Method I instead of Method II. Obviously, Method I costs the government the same as for a patient going to a dialysis center since the in-center cost is the same $110 - $120 (I am not sure of the exact amount; in fact, it may have changed since I last knew what it was.)

But I am sure you will agree it seems unfair to deny reimbursement to home patients for the erythropoietin drug (which helps anemia for kidney patients).

Also, if Medicare will only reimburse one supplier, this will cause problems for home patients who may use two or more to get what they need. In my case, I get the artificial kidneys from a second company since it is the type prescribed and I happen to like this type, also. I can't get all of what I need from either company.

Thanks.

Sincerely,

Benjamin B. ("Bennie") Stubbs

Case of:

Mr. Blaine McElfresh
[redacted]

This was an interesting case.

We were contacted on 1-17-90 by Mr. McElfresh because he was getting denied on claims regarding a glucometer and diabetic strips. The Dr had sent in that he was dependent diabetic, and a necessary medically requested item, but Medicare kept denying it.

1-30-90: I talked with Medicare (congressional unit) and was told to get Dr. Adamczyk to call Dr. Sutlive at Savannah Medicare and talk with him about the neccessity of it. Dr. Sutlive already had all the paperwork stating this, but this was done. Dr. Sutlive then asked for another letter from Dr. Adamczyk for the file about the conversation and request. This was done.

2/22/90: We had a call, Dr. Sutlive had approved and it would be paid.

He has a good many outstanding claims that are due to be covered under the diabetic part, so now I have called these in and he will refile and get info to Medicare. Hopefully, this will be taken care of for him. We are still taking care of it. His son will fax all paperwork to me, and I will fax it directly to Medicare for them. This will be just until these long overdue claims are paid.

(All this took place after Dr. Sutlive came to WR to meeting.)

Roza Adamczyk, M.D.
Neurologist
Neurology, EEG, EMG and Evoked Potentials

[redacted]

Tel: (404) 227-1102

January 31, 1990

Dr. Stiive
Health Care Compare
12052 Middle Ground Rd.
PO Box 61149
Savannah, Ga.

Re: Blaine C. McElfresh
Medicare No: 207-16-8336 A

Dear Dr. Stiive:

As per our telephone discussion on 1/31/90, this is a letter of necessity for Mr. Blaine C. McElfresh.

This is a patient that I have been seeing in reference to peripheral neuropathy which has been quite severe and interferes with his life. The patient has been seen since July of 1989. His peripheral neuropathy work up was positive for the presence of Monoclonal Gammopathy. He was referred to Emory University Clinic and had a nerve biopsy which was negative for the presence of accumulation of ammunoglobulins. Thus far his peripheral neuropathy work up points to the fact that perhaps diabetes is the cuiprative factor in his peripheral neuropathy.

I had requested for him to obtain a Glucometer which he has to use at home. He has been quite diligent in keeping a tab on his daily blood sugars and had noticed that if his blood sugar is above 140, he gradually notices an increase of his weakness and pain and drawing sensation in his legs. However if he maintains his blood sugar within the proper range he has less symptoms. I think that it is essential for him to continue with his Glucometer and I feel that Medicare should approve its home use. The patient was quite disturbed about the fact that he was denied payment on his Glucometer as financially he is not able to afford to purchase it on his own without Medicare's help.

I appreciate your concern and help in this matter.

Sincerely yours,

R. Adamczyk M.D.

Roza Adamczyk, M.D.

RA/cn
cc: Blaine C. McElfresh

Case of:

Mrs. Ethel H. Grey
[redacted]

11-13-89 We received letter from granddaughter, Lee Ann Cladin

She has power of attorney for her grandmother, and executrix of

estate for deceased grandfather.

On July 25, 89 William S. Grey died.

Medicare stopped paying for Mrs. Grey that day, and put in computer that she was dead.

They called Social Security and Medicare several times, and with each blaming the other for the error.

Medicare showed she was alive, but terminated her medicare.

SSA has to correct the mistake on the system.

I called SSA and Medicare several times.

A check finally came, but it was for the deceased Mr. Grey, and could not be cashed. I sent it directly to Medicare Congressional.

A second check came to the estate, and could not be used. We sent it back.

11-29-89, the record at Medicare still not corrected.

SSA had to do another update to see if they could get the record corrected and her termination date off.

1-18-90, we now have the termination date off, and all claims dating back to 7-25-89 will have to be refiled.

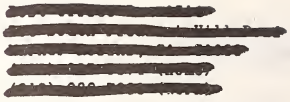
1-26-90: Checks are beginning to come and claims being paid.

Medicare paid nothing between July 89 and Jan 90

and all this time trying to get the termination off Mrs Grey's record.

(a case of deleting the wrong person.)

Claims are now being paid on regular basis.



The Honorable Richard Ray
200 Carl Vinson Parkway
Warner Robins, GA 31088

Dear Sir:

I am a Houston County resident and a federal Civil Service employee. I have recently encountered a serious problem which has not been readily solved. Please give me some advice or help if you can.

BACKGROUND INFORMATION

My grandmother, Ethel H. Grey, is a seventy-five-year old stroke victim and is almost totally blind. She has had two major strokes and has relearned her gross motor skills through extensive physical therapy and absolute determination. Her doctor found cancer last May, and she underwent a hysterectomy. She has high blood pressure, blocked arteries, glaucoma, and various other ailments. She takes seven prescription medications daily. She does not go outside her house unless a family member takes her to the doctor. (Even when we deal with our attorney, he comes to the home to do the work so Grandmama will not have to get out.) She uses a wheelchair, a walker, and a motorized lift chair. She receives Social Security benefits and has Medicare Part A and Part B as well as Blue Cross/Blue Shield High Option hospitalization.

My granddaddy, William Spivey Grey, had lung and bone cancer and died July 25, 1989. He was a retired Civil Service employee and was receiving Civil Serivce Retirement benefits as well as Social Security benefits.

I was appointed executrix of my granddaddy's estate, and I maintain power of attorney for my grandmother. The Office of Personnel Management in Washington has begun my grandmother's survivor's annuity benefits. Blue Cross has changed her insurance to self-only coverage. My granddaddy's Social Security payments have ceased; my grandmother's have continued.

PROBLEM

Medicare has discontinued paying my grandmother's medical bills. They have responded stating that the services were rendered after she became deceased. When I called Medicare, I was told that their records show Grandmama being deceased as of July 25, 1989. I explained that my grandfather died that day and that my grandmother is indeed still alive. He told me it was our responsibility to prove that she was alive.

I wrote a letter for Grandmama to send to Medicare. We attached the hospitalization change of status and my granddaddy's death certificate as well as copies of claims Medicare has refused.

We received a letter from Social Security requiring Grandmama to go in person to their office, bringing an official paper that shows her picture, her signature, her name, date of birth, and sex. The letter states that if we do not respond in 10 days, they may discontinue her payments. After I talked with the office, Social Security agreed to send someone to the house to see if she is alive, but they would still have to see her in person; the office could not, however, tell me when they would be able to do this. Social Security explained to me that they had received a *death alert* on Grandmama. No one in the office knew what caused the death alert.

The rudeness I have encountered on the telephone is appalling. Medicare has specifically suggested to me that I could very well be trying to cheat them out of money and they would not deal with me but must deal with Grandmama in person. Sir, both of my grandparents as well as I have always worked for what we got, paid Social Security and taxes, and have never drawn unemployment or welfare. I understand that some government agencies may encounter erroneous information occasionally and may receive fraudulent claims; this is no cause, however, to act so defensive and accuse a person of such.

I have a legal document stating that I can conduct all her affairs and transact all and every kind of business of whatever nature of all accounts, annuities, etc., which may be due, owing or payable to her. I should, therefore, be able to take care of this business for her.

Sir, the error that has been made is due to a mistake within the Social Security Administration. It is unfair to force an elderly homebound person to prove she is alive. The undue stress caused her by errors of Medicare and Social Security is an injustice and should not be tolerated. Proper maintenance of records by Social Security personnel should be enforced. Employees should be held accountable for the information they disseminate. I expect to deal with professional, courteous, knowledgeable individuals when I call government agencies instead of rude, defensive people who cannot competently and effectively deal with others.

Respectfully,

Lee Ann Cladin

Lee Ann Cladin

Mrs. Adelle W. Carter for James E. Carter (deceased)

Mrs. Carter contacted this office on 11-25-89

Mr. Carter died 8-10-89. Hurt in wreck, Dr Steffanis in Macon said he needed the best therapy available, and found it in Orlando, FL . He checked and no closer facility available for this particular patient. Comatose.

He needed air ambulance for the trip, and could not find one closer than American Air Vac in Scottsdale, AZ for transporting him to FL

The Dr. said this type was a necessity, but Medicare denied the claim as a whole.

Dr. Stefanis would have sent him to Atlanta, or anyplace closer had it been available for his particular injury.

As of 1-26-90, we are still working the case, and now have it so she can file for a hearing with Medicare and sent her the instructions for doing so.

GEORGE S. STEFANIS, M.D., P.C.
NEUROLOGICAL SURGERY
[redacted]
TELEPHONE [redacted]

January 3, 1990

Medicare Aetna Administration
P.O. Box 3174
Savannah, GA 31402-3174

RE: [redacted]

To Whom It May Concern:

The patient was injured quite severely and had multiple medical problems. He was in a comatose state, he did have a gastrostomy and a tracheostomy in. Your questions as to whether there was a near rehabilitation facility, we contacted every facility within our area including program in Nashville, Tennessee and the Chattanooga, Atlanta, Warm Springs, in Virginia and as far away as St. Louis and nothing could be found closer for his particular problem other than the facility in Florida. This was researched thoroughly by our social worker, by myself and by Mr. Carter's family. For that reason and his severe medical problems we felt air ambulance to Florida was the safest way to get him transported to that facility. If you have any further questions regarding this please feel free to call me.

Sincerely,

George S. Stefanis, M. D.

GSS/dd

TO EXPEDITE PROCESSING, THIS FORM WAS
DICTATED BUT NOT SIGNED BY THE DOCTOR

[redacted]

9 January 1990

Congressman Richard Ray
200 Carl Vinson Parkway
Warner Robins, Ga 31056

Attn: Mrs Helen Poole

Re: Jas Ernest Carter (Deceased)
[redacted]

Dear Mrs Poole:

Attached is documentation from Dr George Stefanis as to the medical necessity for my late husband, James Ernest Carter, being transposted by air ambulance from Macon to the Rebound Head Injury facility, Florida Hospital in Orlando, Fl, last April.

I do hope Medicare finds this sufficient justification for the choice of medical facility, as well as for the appropriate mode of transportation for that comatose patient.

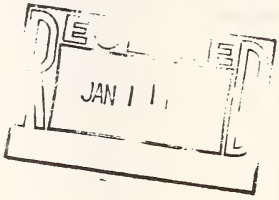
Thank you, Mrs Poole, for your kindness.

Sincerely,

Adelle W Carter

Encl

ADELLE W CARTER



YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

GA-2A-002937

HEALTH CARE FINANCING ADMINISTRATION

AETNA MEDICARE
1203 E MIDDLEGROUND RD
P.O. BOX 3018
SAVANNAH, GA 31402

DECEMBER 08, 1989

HAVE MEDICARE QUESTIONS? CONTACT:
(912) 920-2412 OR TOLL
FREE 1-800-727-0827.

JAMES E CARTER
[redacted]

YOUR HEALTH INSURANCE CLAIM NUMBER
[redacted]

YOUR DOCTOR OR SUPPLIER DID NOT ACCEPT ASSIGNMENT OF YOUR CLAIM(S) TOTALLING $ 1261.00. (SEE ITEM 4 ON BACK).

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIMS. SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL US FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER OR FOR A FREE LIST OF PARTICIPATING DOCTORS AND SUPPLIERS.

MEDICARE DENIED PAYMENT FOR ALL OF THESE SERVICES.

		BILLED	APPROVED
GEORGIA			
1-AMBULANCE	APR 4,1989	$ 1261.00	$ 0.00
MEDICARE DOES NOT PAY FOR THIS MEDICAL SERVICE OR SUPPLY			
TOTAL APPROVED AMOUNT			$ 0.00
MEDICARE PAYMENT (80 PERCENT OF THE APPROVED AMOUNT)			$ 0.00

REMARKS:

THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM AND REFLECTS CORRECTED PROCESSING.

THIS REPRESENTS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM. IF AN UNDERPAYMENT WAS MADE, AN ATTACHED CHECK REIMBURSES THE TOTAL CLAIM ALLOWED AMOUNT MINUS THE AMOUNT ORIGINALLY PAID. IF AN OVERPAYMENT REQUIRING A REFUND WAS MADE AND A REFUND HAS NOT ALREADY BEEN SUBMITTED, YOU WILL BE CONTACTED BY LETTER FROM THE MEDICARE CLAIMS OFFICE.

[redacted]

16 October 1989

Aetna Medicare
P.O Box 37200
Phoenix, Arizona 85069

Dear Sir:

Re: Patient: Jos Ernest Carter
M'Care #: [redacted]
DOB: 22 Nov '09

This is follow-up on claim originally filed 25 Apr 1989, & directed to your Aetna M'Care, 12052 Middleground, Rd, P O Box 6001, Savannah, Ga 31420, on above Patient. After making five written follow-ups to Savannah with no reply, I was advised to refile. I did file again 11 Sep. 1989 292 81319

Having been promised immediate action to compensate for the already long delay, I had had no reply by 4 Oct, so I made a telephone followup. I was told that the claim had been transfered to another Carrier & that an EOMB had been mailed that day. I asked for an explanation of transfer, name & address of Carrier transfered to - a good thing, too, because the EOMB I received had none of this information - this is a follow-up on that transfer to you from Savannah.

F/U on Jas Ernest Carter Claim (Cont'd)

2. Possibly facilitate action on the claim I furnish the following:

While a Pedestrian walking accross a street in Macon, Ga, 13 Dec 1988, my husband, Jas Ernest Carter, was struck down by a moving vehicle - Apparently no one saw the accident except the Van driver, one Robert Prosser of Macon.

Mr Carter had multi-injuries: broken bones, deep lacerations, & saddest of all - severe brain injury - He was rushed by ambulance to the Medical Center of Central Ga, Macon, Ga, where he was a patient until 4 Apr '89 - His broken bones & lacerations were healed - The Medical Center had nothing further to offer IAW the attending Physicians - The Patient was recommended for an acute head injury rehabilitation facility - The attending Neuro-Surgeon, Dr Geo Stefanis, assisted in locating the nearest head injury facility, which turned out to be the Florida Hospital, in the Rebound Head Injury Unit, Orlando, Fl.

The doctors recommended that Patient be transfered to Florida by Air Ambulance only due to Patient's heart & coma condition - After much searching American Aerovac of Scottsdale, Arizona was obtained to accommodate the Patient with a shared (with another Patient) flight - The rest is history.

A.2

- F/U on Dr. Ernest Carter Claim (cont'd)

For your information, I am told that the funds from Vehicle No Fault insurance have all been paid - We have supplemental health insurance with your Aetna Life & Casualty, Tampa, Fl, as indicated on the Claim - due to the long lapse of time since the original claim was filed (25 Apr 89) & because of the enormity of this whole thing, 13 Dec 88 until 10 Aug 89 when my husband died, I respectfully request your prompt action on this Claim -

Sincerely yours,
Adelle W Carter
(or to Dr. Ernest Carter)

Mr. WAXMAN. We will hear from Congressman Ben Jones.

STATEMENT OF HON. BEN JONES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. JONES. Thank you, Mr. Chairman. I would like to echo the comments of my colleagues. We welcome you here to Georgia and we are grateful that you are here. I would also like to say amen to the fact that the State of Georgia is most fortunate to have in our congressional delegation one of only two physicians in Congress. We always look to Dr. Rowland for wise counsel and his expertise on the many health care issues which come before us.

Mr. Chairman, we appreciate too having this opportunity to remark on the Medicare transition from the Prudential Insurance Co. to the Aetna Insurance Co. As you know, in January 1989, Aetna Life and Casualty Insurance Co. assumed the contract for the administration of part B in Georgia.

From the beginning of the transition, our office has received numerous questions from Medicare providers and beneficiaries alike regarding delays in reimbursement, errors in processing and the downcoding of claims. Over the past year, our office has handled over 200 constituent casework inquiries as a result of the transition.

Numerous complaints were received during the first 6 months of the transition regarding delays of reimbursements, many from low income Georgians who could ill afford to wait months for financial reimbursement, and physicians who in some instances had to borrow money in order to meet payrolls. Fortunately, these complaints have markedly decreased.

Our office does continue to receive inquiries concerning claims which are believed to have been erroneously or unfairly judged. In these cases, as well as in the cases of payment delays, Aetna and the Medical Regional Office have given each individual case referred by our office prompt and courteous attention.

In my judgment, Aetna has moved to reduce the difficulties inherent in such a large transition, and I appreciate their continuing cooperation in this matter.

There is one area, however, where the questions from the medical community persist. Many physicians continue to express particular concern with the review of Medicare claims handled by an independent subcontractor, HealthCare COMPARE. They continue to express concern that the review is being conducted primarily by nurses or retired physicians.

Understandably, physicians would prefer to have the review process handled by their peers, practicing medical professionals familiar with the specialty area of the claim. Otherwise, reviews which are inconsistent with the original claim are perceived as having been arbitrarily made.

I know that these hearings will address the issues involved with downcoding, and I look forward to the testimony of the witnesses this afternoon as we explore possible solutions.

As the committee is aware, the Georgia delegation has requested that the Secretary of Health and Human Services, Louis Sullivan, and the Comptroller General of the United States, Charles

Bowsher, direct the General Accounting Office to conduct an investigation into the process by which a transition in Medicare part B carriers is made.

I look forward to the results of that study. It is my hope that we may look to it for guidance on how to avoid the problems of a Medicare transition such as we have experienced here in Georgia.

I wish to acknowledge the cooperation of all the concerned parties in working to find a solution to this mater. Aetna, Medicare, the Medical Association of Georgia and this committee have all devoted much time and energy and effort to this difficult situation.

Again, I thank the committee for holding this hearing this afternoon and for looking into this matter of great importance to so many Georgians. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Jones.

At this time we will hear from Congressman Thomas.

STATEMENT OF HON. LINDSAY THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. THOMAS. Thank you, Mr. Chairman. It is good to have you here in Georgia with us. I think it is always good when our colleagues from other parts of the country can come here to see that we Georgians truly do not speak with an accent.

It is good to be with our good friend, Dr. Rowland, who not only is our good friend and colleague that we are very proud of, but is also our personal confidante and attending physician on the House floor, to the members at least of the Georgia delegation.

Let me say I am glad to have you here today to examine the Medicare program in Georgia. I have got very high hopes that this committee might be the cavalry coming to the rescue.

We have had a nightmare of problems in Georgia over the last year during this transition of Medicare part B carriers. Medicare in Georgia has had literally its own debilitating administrative disease and it has affected the quality of health care for our citizens in our State. So I hope today that you can begin to find a cure.

I have been in the Congress for almost 8 years now and this has been one of the biggest sources of complaint against a Federal program that I have ever encountered in those 8 years. I have had dozens of meetings with physicians, HCFA, Aetna, COMPARE and patients. One of my key staff members devotes much of her time trying to resolve individual Medicare cases, as you have heard other members here testify to today. I have also presided over three different open meetings in my district, which is the home operating office of Aetna. One before the transition and two since then.

At that last meeting 7 months ago, some 200 doctors, their families and friends and staff attended a 3-hour long evening session. I think that tells you something, when you have that many physicians spending that much of their free and precious time to discuss a problem. They documented the problems on paper in a stack that was 2 feet tall, and that was the importance of that meeting, in that the cases were truly documents and the problems documented.

Let me heap some praise on our colleague Roy Rowland who has made that trek with me down to my district to help at one of those public meetings.

My own feeling is that this is not a problem in which we are going to find one real villain that we can all beat up on. Yes, there are some doctors who would like to rip the system off, but they are a tiny minority and they are not hard to track down either. In general, I have found that the doctors are angry because they cannot give adequate treatment to patients, because they spend too much of their time working as accountants and lawyers and bureaucrats, to deal with Medicare red tape.

And if I might digress for just a moment, we have all probably seen the recent articles on the front page of the New York Times about what these complications are doing to the age-old rapport between doctor and patient in this country. Just a few weeks ago, I read the statement carried in the local press by my own family physician that has attended to me and my family's health over much of our lives, who had retired. The alarming thing was here was a man in a rural community who had attended mostly to Medicare patients over the years, who built his practice as they grew over the years and in his closing statement, in his exit from the profession, it was that given the overly burdensome and complicated process under which doctors have to labor today, that he could not honestly encourage either of his sons or his friends to consider the profession today. And I point that out as a sign of the deepness and intrinsic nature of this problem.

I do not believe you will find a villain at Aetna or HealthCare COMPARE. They are fighting to unscramble a very formidable mess and to fulfill their responsibility to abide by regulations.

There is blame enough to go around to everyone, including those of us in the Congress and in the administration.

My pet suspicion is that the heart of the problem is the fact that the Federal Government does not have the money to fully fund Medicare in the atmosphere of the Federal budget deficit and spiraling health care inflation. As a consequence we have opted for a system that is designed to restrain the flow of Medicare dollars through a strangling knot of red tape.

Whether that occurs by intent or accident, it is simply not satisfactory or acceptable. We must do better. We must be direct and honest in explaining how much money we have for Medicare and what we can and cannot do.

I believe that the General Accounting Office study will be helpful. I believe that many of the initial problems have been resolved and the transition is far less painful at this time than it was but there is plenty yet to be done. That is why I appreciate your work in coming here today, and I want to pledge to you my support in every way possible.

Let me conclude by saying that I appreciate the efforts of Aetna and HealthCare COMPARE employees in my district. I have visited them, found them to be very professional and hardworking. They are doing a terribly tough job. I would particularly like to welcome my constituents, Ms. Susan Stallings and Margaret Diener, who will testify later today.

And, Mr. Chairman, thank you for your time and the committee's indulgence.

Mr. WAXMAN. I want to thank each of the four of you for giving the subcommittee its charge this afternoon as we receive testimony and work with you to solve what is a growing problem and an unnecessary problem if the Medicare program is going to live up to its promise to the elderly and disabled in our society today, that is to make sure they can get health care, access to health care, good quality health care, make sure that they will have peace of mind that the bills will be paid by the program that promised to pay it.

Mr. DARDEN. Mr. Chairman, may I make a closing observation about something my colleague, Mr. Thomas, said? And that is that if we are going to have Medicare on the books and we have made a commitment to the people, then we ought to fully fund it.

In my opinion, Mr. Chairman, I think if we are not going to fully fund it, if the administration and Congress are not going to make the funds available to carry it out as the law says it should be, then we ought to take whatever steps are necessary to change the law. But going through this charade of having a program which guarantees certain procedures and not putting the money out there to effectively fund it, I think is very sad.

Mr. WAXMAN. I appreciate that and of course we will be struggling with the budget for the next fiscal year in which we have a budget submitted to us from the President that calls for $5.5 billion cut further in Medicare and that is going to be awfully tough to do if we want the program to continue to function.

I thank each of you for your presentation today and we will look forward to working with you on this problem.

I would like to now ask the following individuals to come forward to testify; Dr. Justin P. Bailey, immediate past president of the Medical Association of Georgia, who will be accompanied by Paul Shanor, executive director and Dr. Robert B. Copeland, American College of Physicians, who will be accompanied by Deborah Prout, director of health and public policy. Please take seats at the table.

We are pleased to welcome you to our subcommittee hearing. Your prepared statements will be made part of the record in full. What we would like to ask each of you to do is to limit your oral presentation to no more than 5 minutes. Unfortunately because of the number of witnesses that we have to testify and the travel schedule—at least for myself, and maybe Dr. Rowland—we are going to have to be very strict on that 5 minute time period. But all the statements will be in the record so we will have a full transcript of the presentations that the two of you and all the other witnesses today wish to make that we can review and share with our colleagues. Dr. Bailey, we will start with you.

STATEMENTS OF JOSEPH P. BAILEY, PAST PRESIDENT, MEDICAL ASSOCIATION OF GEORGIA; AND ROBERT B. COPELAND, GOVERNOR, AMERICAN COLLEGE OF PHYSICIANS

Mr. BAILEY. Thank you, Mr. Chairman, Congressman Rowland and our friends in the Georgia congressional delegation.

Physicians of Georgia are deeply concerned about the devastating effects resulting from the January 1989 change in the Georgia

Medicare carrier and at the same time the implementation of a pilot review program.

Physicians in Georgia have a long history of commitment to elderly patients, treating some 600,000 in 1989 and accepting assignment at a rate of 85 percent. We also have a commitment to the highest level of medical care and ethical standards. Georgia was a national leader in establishing the Georgia Medical Care Foundation, a statewide peer review organization. Our scientific assembly, continuing medical education and PRO review committees each represent vigorous efforts to improve medical practice standards. We are the national leaders in establishing a model program for physicians with drug and alcohol problems.

We come to you with serious suggestions of ways to aid in the restoration of a sense of trust, integrity, fairness and decency to the health care system for the elderly of Georgia. As a patient pointed out to an Atlanta newspaper reporter while discussing his encounters with Aetna, "the sickness did not kill me, but the stress might."

The time for experimentation on Georgia's Medicare patients and physicians is over. The program is a proven disaster. A stable reimbursement review program respected by the Georgia medical community making use of open and clearly stated reimbursement policy consonant with good medical practice is now necessary.

The Medical Association of Georgia asks Congress to request HCFA and Aetna to exercise the provisions in the Aetna/HealthCare COMPARE contract that allows termination of the HealthCare COMPARE program immediately. We firmly believe that decent medical care for our patients demands such a definitive action. HealthCare COMPARE's leaders have made many hollow promises of efficient, medically oriented and experienced reviews. Instead, destruction of trust and profound loss of esteem in and for HealthCare COMPARE has occurred

I would like to take this opportunity to publicly thank the entire Georgia delegation and their excellent staff for the time and effort that they have made on behalf of Georgia's Medicare patients and their physicians. In fact, pressure from our delegation has been so intense that Aetna set up a congressional hotline to resolve problems that were referred from our Representatives and Senators. Aetna's goal of course was to take care of the people who sought relief from Congress and therefore limit congressional scrutiny of their operation. Luckily, thousands of Georgians have refused to accept this deceit and have called the newspapers, AARP, the Medical Association of Georgia and others to register their complaints against Aetna and HealthCare COMPARE.

The Medical Association of Georgia strongly supports the following recommended actions: Immediate termination of the HealthCare COMPARE contract; development of utilization review policies and instructions that are understandable by the physician and patient; streamline the administrative operation of claims processing by engaging an outside consultant management team; amendment of the Medicare law and rules to allow the attending physician to bill when cross-physician coverage is provided; provide that persons rendering services to Medicare patients have a legal remedy when the carriers fails to abide by the law or HCFA's

rules, regulations and policies; and regulate utilization review agencies so at least minimal standards are met.

The Medical Association of Georgia believes that these steps are vital if Medicare is to meet the needs of the citizens of Georgia. We are very concerned about the state of confusion and disarray of the program's administration. The longstanding difficulties present can no longer be attributed purely to a conversion event. While that was true in March 1989, today it is not.

We are committed to working with the Medicare system to provide the quality and appropriateness of medical care needed for our elderly citizens. We ask the same from Congress, HCFA, the carriers and the review agencies.

These problems, issues and solutions we bring to you today are not only local issues, but have national implications. We strongly urge the committee to consider the issues and actions we have suggested today to speed needed change for medical reimbursement for our elderly citizens.

I want to thank you on behalf of all of the physicians and patients in Georgia for making this very special effort to come to our State to learn about our concern. We are indeed appreciative.

Mr. WAXMAN. Thank you very much. Dr. Bailey.

[Testimony resumes on p. 96.]

[The prepared statement of Dr. Bailey follows:]

STATEMENT

of the

MEDICAL ASSOCIATION OF GEORGIA

to the

Subcommittee on Health
and the Environment
Committee on Energy and Commerce

Presented by

Joseph P. Bailey, Jr., M.D.

RE: Health Care for Georgia's Elderly:
Fair Payment for Medicare Services

March 5, 1990

Mr. Chairman and Members of the Subcommittee:

My name is Joseph Bailey, M.D. I am a physician in the practice of internal medicine and rheumatology from Augusta, Georgia, and I am the Immediate Past President of the Medical Association of Georgia. With me today is Paul Shanor, J.D., the Executive Director of the Medical Association of Georgia. We sincerely appreciate the opportunity to appear before you.

RESPONSE TO PATIENT NEEDS OF THE ELDERLY

Mr. Chairman, the physicians of Georgia are deeply concerned about the devastating effects that came about after the change in Medicare carriers in 1989. After AEtna Life Insurance Company and HealthCare COMPARE Corporation took over Part B utilization review, the performance of both has fallen well short of the character of our standards of medical care, standards of fairness, and even standards of decency in the care of our elderly citizens in Georgia. The Medical Association of Georgia appreciates this opportunity to appear before the subcommittee to discuss the previous year's events and to outline our proposals for a positive re-direction of our Medicare efforts in 1990 and thereafter.

The medical profession in Georgia has demonstrated a long and profound commitment to the elderly patients of our state. In 1989, approximately 8,900 Georgia physicians were enrolled in the Medicare program. These physicians were caring for some 600,000 elderly patients and accepting their Medicare claims on assignment at a rate of 85 percent. In 1989, Georgia led the country in new doctors signing up as participating physicians.

Voluntary physician acceptance of assignment has continued to increase at an all-time record high; a fact that is clearly indicative of the physician's involvement and concern for their patients' economic circumstances.

This performance commitment has occurred in spite of the ambivalence about promoting a more pervasive role for government

in health care financing and delivery along with a general philosophical distaste for regulation and the depersonalization of the patient-physician relationship.

During 1988 and 1989, MAG created the Senior Citizens Advocacy Committee to assist elderly patients by providing more and better information about their Medicare benefits and the present constraints that affect their care. Also, during 1989, a Medicare hotline was established to assist physicians and patients in the growing complexities of this troubled system. We presently serve on a Governor's blue ribbon committee to examine the problems of access to health care, including those factors bearing on the elderly. Our local county medical societies have organized programs for the homeless aged, voluntary assignment, patient referral, and other service-delivery strategies to offer our elderly citizens the best possible care. We know of no other profession that gives as much back to its community as does medicine.

Our commitment to the highest level of quality medical care and ethical standards in Georgia is well established. Georgia was a leader in the nation with the establishment of the Georgia Medical Care Foundation, a statewide Peer Review Organization, which is strongly backed by several layers of physician reviewers and advisors. Our Access to Medical Care, Judicial Council, Scientific Assembly, Third Party Payors, Continuing Medical Education, PRO Review, and Alternative Solutions to the Nursing Care Crisis committees each represent continuing, vigorous efforts

to improve medical practice standards. We were the national leaders in establishing a model program for physicians with drug and alcohol problems.

COMPROMISING OF STANDARDS

Unfortunately, a crisis in Georgia medical standards has begun. Georgia's Medicare Program is at an important juncture where a struggle exists between the physician's ethical and moral responsibilities to provide the best level of medical care needed and the program's efforts to deny that care and payment through administrative obfuscation and review policies. It now appears that Georgia standards are being severely compromised.

For almost 20 years prior to 1988, Prudential Insurance Company of America was the Medicare carrier for the State of Georgia. In June 1988, the Health Care Financing Administration (HCFA) contracted with the AEtna Life Insurance Company and its subcontractor, the HealthCare COMPARE Corporation, to begin administration of the Medicare program in Georgia, effective January 1, 1989. As a condition of this contract, HCFA required that AEtna contract with a private profit-motivated utilization review company to carry out its medical utilization and "necessity" review (UR). Later, we were to learn, Georgia's program was to be identified as a "first of its kind" national research project on "private, entrepreneurial" versus "carrier" review.

Although we were the only state to have a private UR company, HealthCare COMPARE, whose sole purpose was to make a profit for

its shareholders, we were to be evaluated in comparison with several other control states - Equicor of North Carolina, and AEtna of Arizona. Two other states, so-called "flexible carriers" -- Indiana Blue Shield and the Louisiana carrier, which is Arkansas Blue Shield -- were to share with HealthCare COMPARE in having a more generous budget and increased latitude for medical policy change and development.

The flexible approach would presumably result in more creative and innovative ways of medical care claims review. This, in turn would provide evidence for a potentially improved utilization management program and better cost control. Health Care Financing Administration's results from this study have yet to be revealed.

HCFA officials explained the change in carriers was, in part, due to the recent decline in Prudential's carrier performance evaluation reports and because of Prudential's publicly stated belief that the program is inadequately funded. Neither physicians nor patients were queried concerning their own assessments of the program or of the consideration for a pilot test with a new carrier and utilization review unit. In fact, after a year of this experimental disaster, neither physicians nor patients have yet been given a formal chance to respond. Since HCFA has not allowed us the opportunity, we appreciate the chance to meet with you. Although increasing federal legislative constraints had added to the program's complexity, its overall operation appeared to be generally satisfactory to the majority of Georgia physicians and Medicare patients at the end of 1988.

EARLY EFFECTS OF THE CHANGEOVER

Six months into the changeover period, in June and July, 1989, a MAG member survey showed a definite and strong dissatisfaction with the new carrier's overall performance. I am including this survey as an appendix to this statement (Appendix I). General service problems were reported by almost 40 percent of the physicians who responded. Claims were estimated to be incorrectly processed by nearly 50 percent. Physicians having Medicare service claims denied for payment were reported at an astounding level of 72 percent. A high percentage of these disallowed claims, upon subsequent review, were -- after considerable effort and expense -- reversed and the payment claims were honored. Physician health care, which was frequently denied or reduced to a lower level of reimbursement, was reported from January to May by those physicians as follows:

MEDICARE SERVICE CLAIMS DENIED OR REDUCED
JANUARY-MAY 1989

TYPE OF CASE	NUMBER ANSWERING THAT THIS OCCURS FREQUENTLY	
	DENIED	DOWNCODED
CONCURRENT CARE	61%	46%
COMPREHENSIVE VISITS	40%	75%
INITIAL HOSPITAL VISITS	23%	67%
DAILY HOSPITAL VISITS	14%	31%
DIAGNOSTIC PROCEDURE	24%	27%
MEDICAL CONSULTANTS	27%	67%

Our survey findings correlate closely with a later patient-based survey hotline conducted by the Atlanta newspapers in November, 1989, in which over 3,000 patient complaints concerning Medicare were received within a 48-hour period (Appendix II). Had more phone lines been available, more calls would have been received (See Article, Appendix III). Since only 15 percent of claims are submitted by patients, this was an extraordinarily high number of calls registering patient complaints.

Both surveys indicated the complaints were not confined to any one population segment or geographic region in Georgia. Large group practices, rural physicians, highly specialized metropolitan area clinics, and a range of medical specialities were all being affected by an interacting series of reimbursement problems and slowdowns.

We must be especially understanding of the impact of Georgia's program upon the sick elderly patient. As reported in the Atlanta Journal-Constitution, the headline read "Medicare in Georgia: Many Live in Fear of a Costly Illness." As the patient pointed out after discussing his encounters with AEtna, "The sickness didn't kill me, but the stress might" (Appendix IV).

I would like to take this opportunity to publicly thank the entire Georgia Delegation and their excellent staff for the time and effort they have made on behalf of Georgia's Medicare patients and their physicians. It is indeed gratifying to know that our elected representatives really do care.

In fact, pressure from our delegation has been so intense that AEtna set up a legislative hot-line to resolve problems that were referred from our Representatives and Senators. AEtna's goal, of course, was to take care of the people who sought relief from Congress, and therefore, limit Congressional scrutiny of their operation. Luckily, thousands of Georgians have refused to accept this deceit, and have called the newspapers, AARP, the Medical Association of Georgia, and others to register their complaints against AEtna and HealthCare COMPARE.

What this system has done however, is make a mockery of the appeals process. In order to find out why a claim was denied or downcoded, one has to go through the following channels in order to be assured of getting an answer: Patient or Physician --- goes to a Congressional Representative --- who calls the Washington HCFA office --- who calls the Regional HCFA office --- who contacts AEtna --- who calls HealthCare COMPARE --- who talks to AEtna --- who calls back to the Regional HCFA office --- who calls back the Washington HCFA office --- who calls back the Congressional Representative --- who contacts the Patient or Physician with a response. And HCFA claims that the success or failure of this grand experiment has yet to be determined?!

Now, one year later, and following a succession of hearings with the Georgia Congressional delegation, interagency committee meetings, and press conferences, claims policy and timely reimbursement problems still significantly persist (Appendix V).

Does this mean there has been no favorable change during the year? No. Many things have improved. Physicians and patients are waiting less time for payment. Communication can now usually be accomplished with the AEtna office within reasonable time limits. Checks are more often arriving at correct locations. The Health Care Financing Administration and AEtna Administration have been more and more attentive to our concerns. This change came only after a highly publicized series of formal statements, national news coverage, congressional pressure, and intervention by the Medical Association of Georgia, the American Medical Association, the Georgia Medical Society (of Savannah), the American Society of Internal Medicine (both national and state chapters), the American College of Physicians (both national and state chapters) and the Georgia Academy of Family Physicians. What then are the sources of discontent?

ARBITRARY ALTERATION OF POLICIES

Government utilization review is designed to focus on the appropriateness and medical "necessity" of Medicare services provided. HealthCare COMPARE was to perform this activity in particularly innovative ways. Utilization Review (UR) is not new to Georgia physicians. A recent poll of one local hospital concerning UR companies involved in clinical decisions showed that, in that hospital alone, over 200 review programs were identified as being currently in place and active. MAG physicians

recognize an appropriate level of physician accountability and peer review. We have worked diligently with review agencies so that they are an aid to improving physician care and not an impediment. Until HealthCare COMPARE arrived, we feel we were successful in our efforts.

HealthCare COMPARE, however, entered the scene with a "meat ax" approach to medical review. Initially, HCFA and HealthCare COMPARE justified this approach by announcing that Georgia doctors were coding for comprehensive visits at a rate 16 percent higher than the national average. (Later, recognizing that their data was flawed since Georgia coded differently than other states, that it was old data, and that it did not take into account that Georgia has a poorer and sicker elderly population than the national average, this accusation was dropped.)

HealthCare COMPARE suddenly put into place a new set of review policies and screens. Instead of targeting their reviews to the few possible abusers in the system, the entire physician and patient population was virtually assaulted. Yet while having to admit that they had misled the public about Georgia doctor's practices, the "meat ax" approach to redoing costs continued unabated.

Unfamiliar and inexperienced with the Medicare Program and the aged population that faced them, HealthCare COMPARE injected rigid and inappropriate policies that were not in keeping with established standards of medical care in Georgia. For example, although state licensing standards required that all nursing home

patients be visited at least once every 30 days by their physicians, HealthCare COMPARE set up a screening process that automatically denied or brought into question any physician visits in excess of four a year. Medicare law requires nursing homes to follow state standards and Medicare law, when followed, requires reimbursment.

Later, HealthCare COMPARE recognized its error and revised the standard. Sadly, though, no redress was offered to the hundreds of very sick, frail and extremely distressed nursing home patients who were told their medical service had been deemed "unnecessary" and would therefore be unreimbursed. No money was ever paid to the patient or the physician for those services rendered as required by Georgia and Medicare law and unpaid for several months.

For those few fortunate patients who, after a visit to the physician's office, were asked to send extensive documentation to substantiate their need for such a visit, a delayed reconsideration took place resulting in payments paid months later. Had the Medical Association been given a chance to review the experimental and highly questionable policies arbitrarily imposed by HealthCare COMPARE as required through agreement with the AMA, perhaps this misapplication could have been averted.

Other policy blunders occurred in comprehensive office and hospital patient services, concurrent care, and medical consultations as have been uncovered in the MAG survey of services conducted in June and July of 1989. The major thrust of the

HealthCare COMPARE effort, however, appeared to be deliberate and could not be attributed to inadvertent reductions of service. The reductions were across the board, of all comprehensive and extended level medical services in outpatient, hospital and nursing home settings for the elderly patients in Georgia. No distinction was made, whether one was an experienced, highly specialized practitioner, an internist whose cognitive diagnostic work was a regular aspect of one's practice, or a physician in general or family practice.

After some months of widespread downcoding, a comprehensive service policy statement was published declaring that a strict definition of the CPT code description for comprehensive services would be used for review purposes by HealthCare COMPARE. Their assertion was that a comprehensive examination must include every aspect of the code's definition. HealthCare COMPARE went on to insist that a comprehensive examination would be indicated only once in a patient's lifetime. Beyond that, significant and persuasive documentation would be required.

This is in sharp contrast with Georgia's previous carrier who had clearly instructed Georgia physicians to bill for a comprehensive physical whenever it was performed. This was recently reiterated in a February 4, 1990, letter from Dr. Eugene J. Gillespie, the former Medical Director of Georgia's Part B Medicare program under Prudential to Dr. Thomas J. Anderson, Jr., the Chairman of the Board of the Medical Association of Georgia. I have also included this letter in the Appendix to my statement (Appendix VI).

I would like to bring to your attention several typical examples of other arbitrary patterns of service downcoding impacting elderly patients that have occurred as recently as a few months ago:

HIGHLIGHTING THE PROBLEM WITH SPECIFIC CASES

Case #1 - After spending an hour in an emergency room, completing a physical exam on a 71 year old male patient with extensive problems relating to congestive heart failure, hypertension, chronic atrial fibrillation, prostatism and arthritis, Dr. Rodney Smith's comprehensive visit was downcoded to a limited level of service. The physician was allowed to bill him at a charge of $18 which would then be reimbursed to the patient at $14.40 (Appendix VII).

Case #2 - Dr. Robert Powers, a vascular surgeon, provided a consultation on a patient who had been admitted to the hospital for surgery and later had a stroke. A complete physical was performed, a conference was held with the patient and his wife, and the referring physician. The billed intermediate level of service was downcoded to a less extensive procedure (Appendix VIII).

In other similar cases, non-participating physicians suffered a further injustice by being told to repay the patient for the overcoded and overbilled amount.

In this connection, a recent AEtna publication of Maximum Allowable Actual Charges (MAAC) for the four geographic regions of the state showed that a rural physician in Valdosta, Georgia, would be allowed to charge a total of $14.95 when his comprehensive code was downcoded to a brief visit. The comprehensive service MAAC was averaged at $46, a difference of approximately $32. For a participating physician, the approved amount for reimbursement is even less -- hardly enough to bail out the Medicare program from its projected high growth and high cost budget with a statistically aging statewide population.

Finally, in December, 1989, almost a year later, a change was made in the policies by HealthCare COMPARE with an apologetic nod that a mistake had been made. No attempts were made to go back and rectify the loss. It's interesting, though, on the other side of the ledger, that if a physician audit reveals some error in coding, or some other practice deficiency, a repayment estimate is made for all possible occurrences during a previous period. This is not an equitable or consistent method to correct discrepancies or errors on either side of the examining table. In fact, it is downright unjust.

Other policy approaches that restricted or eliminated the patients' and/or physicians' ability to receive "medically necessary" approved care and payment were related to the various medical specialities or treatment codes. Dr. John S. Turner, Jr., Professor and Chief of the Emory University School of Medicine, Division of Otolaryngology in Atlanta, discovered in July, 1989,

that for several months patients throughout the state had been denied coverage for sensory neural hearing loss, a condition clearly treatable and traditionally covered by Medicare. It took several months after recognition was made of this gross mistake, for a correction to be published in the carrier newsletter. Again, no payments were made retroactively to those physicians who had practiced good medicine (See Appendices XI and X).

In January, 1990, Dr. Albert Wildstein, a Board Certified Vascular Surgeon in practice in Atlanta and Chairman of the Surgical Quality Assurance Committee for Emory University at Crawford Long Hospital, reported another, more recent policy descrepancy relating to non-invasive vascular testing which he indicated was unique in Georgia. He documents HealthCare COMPARE determinations regarding medical appropriateness of vascular testing and reimbursements that he feels are clearly medically incorrect and which have had a profound effect (Appendix XI).

Further empirical evidence could be given to substantiate HealthCare COMPARE's myopic policy imperatives (See Appendix XII). But of even greater importance, is the effect the policy changes have had on the patients themselves and on the level of confidence and trust in their physician. For every inappropriate policy established, hundreds or even thousands of letters advised the patients they had received a "medically unnecessary" service. In many instances, further implications were made that patients originally were overcharged for care and that physicians would need to reimburse the patients. These events have resulted in tremendous misunderstanding and significant distrust.

SEARCH FOR A FEASIBLE SOLUTION

HealthCare COMPARE's leaders have made many promises of efficient, medically oriented and experienced reviews. Instead, repeated instances of misrepresentation, a lack of clinical review integrity and a lack of responsibility have occurred. The trust has been destroyed and can never return. In fact, it would be difficult to overemphasize the low esteem in which Georgia physicians hold HealthCare COMPARE after a year of distortions, evasions, and countless problems.

Although HealthCare COMPARE states it is making no profit from its review activity, we contend that the financial incentive is their most important driving force. Although HealthCare COMPARE frequently boasts of a broad interdisciplinary panel of physicians, most decisions are brought to the attention of their two full-time, in-house medical consultants.

We strongly question the appropriateness of decisions made by these two review physicians, whose principal specialties are in the area of obstetrics and gynecology.

Very recently, HealthCare COMPARE has reported a new 20-person Georgia specialty panel, one we hope is of more substance than rhetoric. Heretofore, the reimbursement review process they administer has appeared to run roughshod on thoughtful and prudent medical decision-making by the state's physicians.

Physicians entered the practice of medicine to be able to treat patients, and carry out that treatment in the best possible way -- with the best technology, the highest degree of skill, and within an atmosphere of trust and sensitivity. These same physicians are now preoccupied with whether the care they offer can be paid for at all; they daily face a barrage of administrative minutia and an increasing interference with, if not erosion of, patient trust. The cumulative effect has been a severe dissolution of the physician-patient relationship and an unintended rationing of elderly patient care within the State of Georgia.

AN UNACCEPTABLE PATTERN OF REIMBURSEMENT ERRORS

Of less obvious impact than an elderly patient's failure to receive adequate reimbursement has been the administrative operational end of "getting claims paid" by the AEtna Life Insurance Company. At MAG's instigation, monthly advisory meetings began with the carrier in June, 1989, bringing forth regular reports of improvements in claims backlog and payment time, telephone communication, etc. This seems to be in some contrast with what is reported to us by physicians and patients. As recently as last week, AEtna missed another important deadline for notification of state physicians of their new MAAC profiles and participation agreement for 1990. The normal release date of this information is in December of each year, but Congress made an

extension this year to February 28. AEtna was unable to meet that extended deadline, and was granted a new date of March 7. Based on the inforamtion that AEtna is required to give, physicians have until April 1 to make decisions on whether they will participate this year. What this means is that instead of four or five weeks to make a crucial decision, Georgia physicians will have less than three weeks because HCFA was unwilling to change the physician deadline.

In other years, this situation would have been a real dificulty, but this year it creates unique pressures because of conversion inaccuracies and other problems with data last year.

With AEtna's reclassification of physician speciality identification, and conversion of profiles from Prudentials' to AEtna's data sets, there is particular concern about the accuracy of the information. Physicians will be given less time to scrutinize the data and weigh their participation decision properly.

This year will be used to set the volume performance standards of the new relative value scale (RBRVS) system approved by Congress to be phased in over the next few years. The data that is coming late to physicians, and the decisions physicians are forced to make in a limited time frame, will affect their practices and their patients for many years.

This is just another example of AEtna's inability to stay on a schedule and also just another example of the inequity between the system's ability to give itself reprieves while physicians are kept to deadlines.

Problems are still reported in the areas of:

- Reductions, errors, and inconsistencies in the "allowed amounts" being paid to physicians from previous levels.
- Persistent inappropriate denials of claims due to concurrent care.
- Computer-based data retrieval errors.
- Lengthy delays in response to requests for claims reviews.
- Confusion in application of the relative value scale for anesthesia services with fees being reduced at estimates of from 15 to 20 percent.
- Confusion in assigned versus unassigned claim remittances.
- Erroneous claim denials or delays for a variety of reasons (errors in death dates, overpayment confusion, coding modifiers, etc.)

Since January 1 of this year, some 50 documented letters of physician complaints concerning the AEtna Medicare program have been received in the Medical Association of Georgia office. Three times that number of telephone complaints, approximately 150 calls, have been received as well.

It is interesting to note that the number of calls received by Georgia's Congressional offices in 1989 was such that a special Congressional hotline was established to handle these matters. Complaints for 1989 take up more than two large file drawers of space. A list of just the 1990 physician complaints are catalogued in Appendix XIII.

On a broad scale, we can tell you about the statewide error in clinical laboratory payments in October and November, 1989, in

which an unnumbered list of procedures were reimbursed at 80 percent rather than 100 percent. When we reported it to AEtna, the error had been going on for at least 30 days, statewide, and had not been detected by systems monitoring. Furthermore, the response was so atrocious when we asked for corrections, that we had to demand it in writing (see Appendix XIV). The date of death error affecting numbers of patients was reported by an Emory University physician who had had some 150 claims rejected because the patients' death dates were reported to have preceded the date of medical services. This news was a great surprise to him and his patients who were alive and well! AEtna required that the physician provide verification of the fact the patients were alive in order to process the claims. Just last week we received a letter explaining the still unsatisfactory performance of AEtna in handling just Medicare-Medicaid claims (See Appendix XV).

While we have seen marked improvement in many areas in the AEtna operation, the preponderance of evidence appears to reveal significant administrative deficiencies. Deficiencies that we, nor the Congressional offices should need to continue to handle.

After fourteen months of operation, plus start-up time, we should not still be going through a "new carrier" conversion process. And yet here we are, still trying to determine why AEtna cannot meet normal standards of carrier operation.

CONCLUSION

Mr. Chairman, I suggest we take the opportunity provided in this hearing and in this new decade to reconsider the reimbursement and utilization framework for the elderly patients in Georgia. We believe that a number of immediate actions should be considered:

- Termination of the formal contract arrangements with the HealthCare COMPARE Corporation of Chicago.
- Development of a new, simple-language, Utilization Review instruction set that enables physicians to know and track changes in medical review policies for approvable services to the elderly. This includes computer screens in use for actual reimbursement decisions.
- Engagement of an outside consultant management team to assist in streamlining the administrative operation of the claims processing in light of pending legislative reform; more specifically the use of the RBRVS for reimbursement.
- Launching of a public relations effort between the Medicare carrier and Medicare recipients and the physician community to re-establish mutual physician-patient trust concerning reimbursement decisions.
- Completion of claims adjustments to adequately compensate for financial loss and provision of adequate explanation to the patient in case of misapplication of policies.
- Amendment of the Medicare law offered by Senator Howell Heflin of Alabama that would allow the attending physician to bill for Medicare even when coverage is provided by a covering physician. As Doctor - and Congressman - Rowland knows, such billing procedure provides that payment flows with responsibility, and provides for less patient confusion. Over forty-three states currently bill Medicare in this manner, and Senator Heflin's amendment would simply recognize current practice. (See Congressional Record, Vol. 136, No. 7, Feb. 1, 1990.)

- Introduction of language in section 1869 of the Social Security Act to provide that persons providing services to Medicare patients may have a legal remedy in the patient's or their own name when the carrier fails to abide by the law or HCFA's regulations, rules, or policies. Our proposed language is an attachment in the appendix (Appendix XVI).

- Regulation of utilization review agencies. There are at present no standards for either the companies or their reviewers. The insurance companies are regulated, the physicians are regulated, but there are no state or federal standards for UR companies. They can claim to hire physicians, but there are no standards to require that those hired have ever practiced, or if they have ever had their license revoked or suspended. We also have no standards showing that the reviewers are not impaired from drug or alcohol abuse, or that they are not felons. Some minimal standards should apply to insure that the reviewers recognize good, competent medicine when they see it.

- When a large number of denials occurs, and is caused by a single policy and affects several physicians, the physicans should be able to appeal in a group and be represented by their state medical society or association.

- Extend physician time frames for "participation decisions" by the same amount of time granted to the AEtna carrier.

The Medical Association of Georgia is committed to working with the Medicare system to provide the quality and appropriateness of medical care needed for its elderly citizens. The State of Georgia has a very large and growing Medicare population that often requires a higher intensity of treatment than the rest of the population. Many times this requires an expensive service. We believe that an administratively sound and efficiently run Medicare program is the best vehicle to make these distinctions.

We strongly urge the Committee to consider the issues and actions we have raised today to speed needed changes for medical reimbursement in Georgia.

A P P E N D I C E S

APPENDIX I

SELECTED SERVICE PROBLEMS
ENCOUNTERED IN THE
1989 MAG SURVEY OF
MEDICARE CARRIER PERFORMANCE

As of July 1989

1330 responses (22%) were received from the 6,021 questionnaires mailed to MAG membership in June with a follow-up letter in July. This low response rate raises questions as to the perceived importance of the Medicare Carrier issue.

1148 of these indicated that the percentage of their patients covered by Medicare exceeded 10%. These 1148 were used in generating the following results.

Service Problems - of the 1148:

438 (38%) reported at least one service problem during the period 12/88 to 5/89. The average number of problems for all responses was 33 for the six months or 5.5 per month.

372 (32%) reported at least one problem during the month of May. The average number of problems was 15 for that month.

Disposition of claims - of the 1148:

1037 (90%) provided estimates of the number of Medicare claims filed in the last six months. The average number of claims were 1,033 or 172 per month.

462 (40%) reported claims still outstanding that were filed before 1 Jan 89. For those reporting, the average number of claims outstanding was 65.

543 (47%) reported that they had experienced claims being incorrectly processed in the period since 1 Jan. An average of 23% of all claims were reported as incorrectly processed.

392 (34%) reported similar experiences since 1 May. The average percentage of all claims incorrectly processed was reported as 18%.

831 (72%) reported having claims denied during the last six months. The average number of claims per respondent reported as being denied was 53 or 5% of all claims submitted.

303 (26%) reported that they had experienced claims being initially denied as not being "medically necessary or appropriate."

Denied or Downcoded

The following experience was reported in having claims either denied or downcoded for different types of cases:

	Number answering question	of those, % answering that this occurs frequently
concurrent care		
denied	924	61
downcoded	599	46
medical consultations		
denied	526	27
downcoded	870	67
comprehensive visits		
denied	512	40
downcoded	911	75
initial hospital visits		
denied	491	23
downcoded	863	67
daily hospital visits		
denied	840	14
downcoded	519	31
diagnostic procedures		
denied	829	24
downcoded	437	27

Note: These results are based on a self-selected response from MAG membership. A statistically designed sample yielding valid information is currently being queried and these results will be available in the near future. Use the following results with caution.

APPENDIX II

THE ATLANTA JOURNAL-CONSTITUTION
MEDICARE CALL IN

The Atlanta Journal-Constitution invited Georgia Medicare patients to call in to discuss their claims processing problems this year.

Telephone lines were open Wednesday and Thursday.

Callers were invited to use Touch-Tone phones to respond to an automated questionnaire. The lines received 2,942 calls. About two-thirds of all callers answered at least some of the questions. Some who hung up were unable to respond to questions because they didn't use a Touch-Tone phone.

The call-in was not a random sampling of Medicare recipients, and no scientific conclusions can be made from the data. However, the results do suggest widespread discontent over Aetna's administration of Medicare claims in Georgia.

HERE ARE THE QUESTIONS AND THE RESPONSE TOTALS:

1. Have you filed a Medicare claim this year?

yes	1,875	94.9%
no	100	5.1%

2. How would you rate the overall Medicare service this year compared to last year?

Better	89	4.8%
Same	134	7.2%
Worse	1,632	88.0%

3. After filing a claim this year, what is the longest period that you have had to wait before receiving reimbursement from Medicare?

Less than 2 months	145	7.9%
2-6 months	737	40.0%
More than 6 months	961	52.1%

4. This year, has the portion of your medical bill reimbursed by Medicare gone up, remained the same or gone down?

Greater	56	3.1%
Same	173	9.5%
Lower	1,600	87.5%

Page Two

5. How often, if at all, does your doctor agree to collect payments directly from Medicare?

Usually	300	16.5%
Sometimes	681	37.4%
Never	841	46.2%

6. Have you experienced a problem with a Medicare claim this year?

Yes	1,651	91.3%
No	158	8.7%

7. How would you rate the response from Aetna to your problem?

Good	31	1.9%
Fair	119	7.2%
Poor	1,331	81.0%
Didn't call Aetna	163	9.9%

8. Has your problem been resolved?

Yes	257	15.7%
No	1,384	84.3%

9. Has the problem caused you to stop or delay medical care?

Yes	624	45.5%
No	748	54.5%

Note: Source of information from article dated November 19, 1989 in the Atlanta Journal-Constitution

The Atlanta Journal ◻ THE ATLANTA CONSTITUTION ****** SUNDAY, NOVEMBER 19, 1989

Nearly 3,000 Callers Complain About Aetna

■ *Medicare patients tell of the problems they've had. Page P3.*

More Than 80% Say Problems Are Unresolved

By Robert Snowden Jones
Staff Writer

Although Aetna Life Insurance Co. says the worst of its Medicare administration problems are behind it, you can't tell that to nearly 3,000 Georgians who called The Atlanta Journal-Constitution's response line last week to register complaints.

■ More than eight of 10 callers said their problems with Aetna, which serves as Medicare's administrator for payment of doctor bills in Georgia, were unresolved.

■ Nearly nine in 10 callers said their Medicare reimbursement rates had declined since Aetna took over as administrator in January.

■ About half the callers said they have waited more than six months for Medicare to help pay for their doctor visits.

■ Nearly half the callers who said they've had trouble getting reimbursed for their doctor visits said they have stopped or delayed medical care because of problems with Aetna and Medicare.

In the words of one Medicare patient who lampooned Aetna's TV commercial, "Aetna, I'm mad I met ya."

Although the call-in is not a random sampling of Medicare recipients and therefore no scientific conclusions can be made, it suggests that Aetna still has a way to go in ironing out problems it inherited from the former administrator, Prudential Insurance Company of America.

MORE Continued on P2

R 19 1989.....

More Than 3,000 Complain About Aetna

From Page P1

About one-third of the callers did not complete the automated questionnaire. Many weren't able to because they didn't call on Touch-Tone phones.

U.S. Rep. J. Roy Rowland of Dublin said he was disturbed that many callers said Aetna problems were discouraging them from seeking medical care. "The fact is that when people don't feel their doctors are getting paid, they won't go to them," he said. "They have that much self respect and dignity.

"That concerns me because it puts our whole medical system in jeopardy," said Mr. Rowland, who has spearheaded the Georgia congressional delegation's inquiry into Medicare reimbursement for doctor bills in this state.

Until the extent of the state's Medicare woes were reported two weeks ago, the delegation handled most cases through staffers in their Georgia offices. They relied on special phone numbers and representatives provided by Aetna to give speedy service to constituents who called.

Last week, however, the delegation stepped up its efforts to bring pressure in Washington.

Mr. Rowland drafted a letter to Louis Sullivan, secretary of health and human services, detailing the extent of the Medicare reimbursement problem in the state and asking him to take action to improve the situation.

Citing preliminary data from the Journal-Constitution response line, the letter said that "while we have been effective in assisting those who have contacted us, there are many beneficiaries and physicians who remain victims of the deficiencies in the system."

Mr. Rowland has asked the delegation to sign the letter.

Georgia Sens. Wyche Fowler and Sam Nunn also drafted a letter concerning Georgia's Medicare situation last week addressed to Sens. Lloyd Bentsen (D-Texas) and Bob Packwood (R-Ore.) of the Senate Finance Committee, which oversees Medicare.

Aetna said Friday it will begin operating Monday a toll-free hot line for Medicare enrollees who have not been able to get their payments straightened out.

"Aetna is establishing a hot line of its own to accommodate your readers that have a specific question or who have raised a complaint to you," said Robert S. Champagne, director of the division that handles Aetna's Medicare payments for doctor bills.

Mr. Champagne said Friday he believes many of the complaints received on the newspaper call-in line were caused by a backlog of claims Aetna inherited in January from Prudential.

He conceded errors occurred because of an inexperienced staff and the backlog. But Aetna has intensified training and introduced new quality checks to improve accuracy, he added.

"This is still an area where we feel improvement can be made," Mr. Champagne said.

He said that 91 percent of claims from doctors who accept direct payment from Medicare are processed within 17 days, and 93 percent of claims from other physicians and their patients are processed within 24 days.

"Overall, 97 percent of all our claims are processed within 60 days," said Mr. Champagne, who added that the Savannah office gets more than 2,000 calls a day. "I estimate that only 7 percent of these represent complaints, most of which are promptly resolved."

But many Medicare patients and doctors say problems are much more severe than Aetna says. They are upset that Aetna and its subcontractor, HealthCare Compare Inc. of Chicago, have been downgrading or denying many comprehensive claims in addition to delaying payments through inefficiency or mistakes.

Doctors level part of the blame on the Health Care Financing Administration (HCFA), the financial arm of Medicare, because it required Aetna to hire an independent reviewing company as part of an experiment to clamp down on runaway medical costs.

HealthCare Compare is the first for-profit company in the country to land a contract to review Medicare claims. If it succeeds in reducing Medicare payouts in the Georgia pilot program, it stands to win contracts in other states.

Barbara Gagel, director of bureau program operations for HCFA in Maryland, said some of the reimbursement problems stem from a few doctors ordering unnecessary procedures or treatment.

Unless the doctor accepts assignment — which means he will accept certain payments from Medicare instead of requiring the patient to pay the entire bill — the patient accepts the responsibility for paying for any treatment that Aetna deems unnecessary.

The Medicare Call-In at a Glance

- The Atlanta Journal-Constitution invited Georgia Medicare patients to call in to discuss their claims processing problems this year.
- Telephone lines were open Wednesday and Thursday.
- Callers were invited to use Touch-Tone phones to respond to an automated questionnaire. The lines received 2,942 calls. About two-thirds of all callers answered at least some of the questions. Some who hung up were unable to respond to questions because they didn't use a Touch-Tone phone.
- The call-in was not a random sampling of Medicare recipients, and no scientific conclusions can be made from the data. However, the results do suggest widespread discontent over Aetna's administration of Medicare claims in Georgia.

Here are the questions and the response totals:

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No	1,384	84.3 %

9. Has the problem caused you to stop or delay medical care?

Yes	624	45.5 %
No	748	54.5 %

Aetna Opens Medicare Hot Line

Beginning Monday, Aetna Life Insurance Co. will open a telephone hot line for Georgia Medicare patients who have had problems with reimbursements for their doctor bills. The number is **1-800-759-3985.** Ask for Carolyn Dyer, Delia Niles or Penny Patterson. Aetna's regular toll-free number for Medicare questions, **1-800-727-0827**, remains open.

TOM RITTER/special

Margaret and George Callihan: Their son (standing) G. Christian, who spells his name Callahan, says a catastrophic illness would 'wipe them out.'

Medicare in Georgia: Many Live in Fear of a Costly Illness

11/27/89

By Susan Harte
Staff Writer

Early this year, an avalanche of illnesses — three heart attacks, colon blockage, bladder infections and pulmonary edema — struck Marion Edward Cheek of Albany.

His hospital treatment between January and mid-April cost more than $100,000. That did not include fees due personal-care physicians, anesthesiologists and radiologists.

Shortly after Mr. Cheek left the hospital, he began receiving a stream of claim denials from Aetna Life Insurance Co., Medicare's administrator in Georgia. Ever since he has been caught in a cycle of appeal, denial and frustration.

"The sicknesses didn't kill me, but the stress might," Mr. Cheek, 66, said last week.

Many elderly dread getting sick. They worry that their money will run out before they get better or die. And they worry about becoming a financial burden on their children.

Medicare — federal insurance for the elderly and disabled — is supposed to protect them against the financial perils of illness. But many of the 800,000 Georgians eligible for Medicare believe the program has failed them this year.

To those struggling with health and financial problems, a confusing Medicare system only adds to their feeling of vulnerability.

"They feel helpless and powerless," said Louise A. Hamilton, an Emory University public health administrator. "[Many] are not intellectually sophisticated enough to plug into things like AARP [American Association of Retired Persons] drug discounts.

"And the paperwork, they're emotionally incapable of dealing with it,

MEDICARE Continued on **B6**

NOVEMBER 27 1989 .....

Medicare in Ga.: Elderly Fear Costly Illness

Many Say That in '89, The System Has Failed

From Page B1

which just causes more helplessness."

Hundreds of Medicare patients and doctors believe the program has deteriorated since January, when Aetna replaced Prudential Insurance Company of America as administrator of Medicare reimbursements for doctor services in Georgia. Aetna inherited some 600,000 leftover 1988 Medicare claims from Prudential.

Meanwhile, the Health Care Financing Administration (HCFA), which hired Aetna, decided to test a strategy never before tried in any state: to trim claim payouts. It required Aetna to hire a for-profit firm to review claims under strict new standards.

The results have provoked a storm of protest. Nearly 3,000 people phoned a Medicare response line operated for two days this month by The Atlanta Journal-Constitution. An overwhelming majority of the callers said Medicare service has been worse this year than last.

"They've [Aetna] got the unmitigated gall to say in the paper that they're caught up [with claims backlogs]? It's an out-and-out lie," said Mr. Cheek, a former World War II Navy fighter pilot and 27-year veteran of the FBI.

Like other retirees, Mr. Cheek once thought he and his wife of 45 years would have enough money to live out their lives in relative security. He no longer thinks so.

With apprehension in his voice, Mr. Cheek declared that everything he worked for all his life is threatened by the health-care mess.

"I'm in [deep trouble] as far as bills are concerned. No insurance pays for everything. It's $3,000 here, $800 there and $799 somewhere else . . .

"We get 3 or 4 percent increases every other year. Congress gets a *33 percent* increase. I'll be very honest: The folks in [political] office are *not doing it* [their jobs]."

Mrs. Margaret Callihan, 80, of McRae, Ga., has been having similar thoughts about the stresses engendered by health, cost and

HERB PILCHER Staff

Marion Edward Cheek, with wife Jewell, complains about elderly getting '3 or 4 percent increases every other year [while] Congress gets a 33 percent increase.'

masses of confusing paperwork. Her husband, 86, is a retired dentist.

"Every month when I pay bills, I'm worried," she said softly. "I see it [assets] melting away — every month eats more and more.

"If you have $1 million, you're OK. If you have nothing, you're OK. But if you're in the middle, woe is you."

Their 55-year-old son, G. Christian, who spells his name Callahan, worries about his father and mother being overwhelmed by official forms.

"It's the enormity of it," said Mr. Callahan. "And they're afraid. A catastrophic illness, which is their greatest fear, would wipe them out. . . . Aetna has spoiled their golden years."

Marianne K. Craft of Atlanta has witnessed the "ongoing nightmare" of her parents' health care. And she knows "that we're not unique."

Although her father, 80, is terminally ill, he's still vexed about medical costs. When he frets, his wife and daughter reassure him. Then they go home with nagging distress.

"I've been beside myself. It's the worst thing I have ever been through," Mrs. Craft said, emphatically. "It's the unfairness of the system . . . you never escape. And my mother has the burden not only of his impending death, but also of the money.

"She has been a very courageous person. But this is humiliating for her."

Mrs. Craft's mother, Margaret W. Kendrick, feels indignant as well.

"My husband almost had to die before they'd even let him go to the hospital. You talk about helplessness? I was in awful shape," she declared. "Had it not been for my children, I never would have been able to handle this. I've spent almost all we had. We had to sell stock that was our nest egg."

In a quivering voice, Mrs. Kendrick murmured, "I don't know what's going to happen."

An Albany orthopedic surgeon understands her dilemma, but insists that physicians are just as helpless as the sick they treat.

"These folks, bless their hearts, don't know how to deal with a system that thinks first about the dollar bill and nothing about human needs," said Charles B. Gillespie, who absorbs unpaid Medicare costs rather than turn down patients. "[The government] makes ridiculous rules about when we can admit people, regardless of the needs of the patients."

For example, Medicare won't pay to allow a surgery patient to enter the hospital a day before the operation. "With joint replacements in the elderly — people 73, 75 years old — they're scared to death to get up in the middle of the night to drive to a hospital [for a mandated morning-of-surgery admission]," Dr. Gillespie said.

In the eyes of all those interviewed, there is a discrepancy between the insurance industry's seductive advertising that depicts happy, well people and the insurance industry turned suddenly distant and hostile.

They also see a discrepancy between a government that extracts taxes for worldwide aid, then subjects its own middle-class citizens to what they regard as unpardonable neglect.

"One of these days, I'll be a citizens' rights activist," stated a determined Mrs. Craft.

"I'm above average in education and intelligence," said an equally adamant Mr. Cheek, "and I've worked for the government. I understand bureaucracy. But if Medicare can treat *me* like this, what in the world are they doing to the uneducated, sick and elderly who don't know how to stand up?"

APPENDIX V

MAG CALENDAR OF EVENTS

MEDICARE CARRIER CONVERSION
(1988-1989)

June 28, 1988	- AEtna signed contract becoming Medicare fiscal Intermediary in Georgia (annually renewable)
	- Implementation period (June 10, 1988 to December 31, 1988)
	- Operational period (January 1, 1989 - September 30, 1989) October 1, 1989 - September 30, 1990 (Prudential carrier dropped reportedly because of decline in carrier performance reports)
September 28, 1988	- HealthCare COMPARE Corporation signs contract with AEtna Life Insurance Company to become medical and utilization reviewer (similiar contract period to AEtna except allows for automatic renewal for two consecutive one year periods)
September - December 1988	- MAG holds preliminary meetings with AEtna and HCC regarding conversion planning
November, 1988	- MAG holds Medicare Educational Workshops with HCC representatives for physicians
January 1, 1989	- AEtna begins official operational management of Medicare program
March 10, 1989	- MAG President Nettles sends report to MAG physician's on Medicare difficulties and sets up MAG Medicare Hotline
March 23, 1989	- Letter from Georgia Congressional delegation sent to Louis Hayes, HCFA Administrator requesting investigation of AEtna Medicare
March 28, 1989	- Georgia Medical Society and U.S. Representatives Lindsay Thomas hold Medicare hearing in Savannah (over 250 physicians offer testimony)
April 19, 1989	- MAG statement on Medicare Conversion presented to Georgia Congressional Delegation and HCFA Director at hearing in Washington, DC

May 25, 1989	- Advisory group meeting at the Savannah Medicare office
June 22, 1989	- Advisory group meeting at the Savannah Medicare office
June - July, 1989	- MAG Survey of Medicare Carrier Performance conducted
June, 1989	- MAG begins monthly Advisory Committee meetings with AEtna, HCFA, and HealthCare COMPARE
July 20, 1989	- Advisory group meeting at HCFA Regional Office in Atlanta
August 16, 1989	- Advisory group meeting at the Savannah Medicare office
August 30, 1989	- Second Georgia Medical Society Hearing held in Savannah with Congressmen, Barbara Gagle and Georgia physicians (over 200 physician attend)
	- Georgia Congressional Delegation requests General Accounting Office to conduct Medicare investigation in Georgia. GAO has agreed to do so with tentative date set for September, 1990
September 19, 1989	- MAG leadership, Dr. Joe Nettles, Dr. Joe Bailey, and MAG and AMA staff meet with Barbara Gagle, Chief of HCFA operations re: comprehensive service downcoding (Georgia physician claims for comprehensive services suspended are reduced or denied at level of 75.1%; initial consultations at 40.2% and concurrent care at 28.5%)
September 20, 1989	- Advisory group meeting at the Savannah Medicare office
October 18, 1989	- Advisory group meeting at the Medical College of Georgia in Augusta
November 15, 1989	- Advisory group meeting at the Savannah Medicare office

December 12, 1989	- Members of Georgia Congressional delegation meet with HHS Secretary Louis B. Sullivan
December 13, 1989	- Advisory group meeting at the Medical Association of Georgia in Atlanta
December, 1989	- HCC officially changes comprehensive policy statement and documentation requirements allowing a more flexible interpretation.
	- AMA passes Georgia Delegation Resolution to change Medicare law on the covering physician
January 16, 1990	- Advisory group meeting at the Savannah Medicare office
February 15, 1990	- Georgia Congressman Richard Roy holds Medicare Hearing in Warner Robins with local physicians, MAG, HCFA, and AEtna
February 21, 1990	- Advisory group meeting at HCFA Regional Office in Atlanta
March, 1990	- Representative Henry Waxman, Chairman Subcommittee on Health to hold hearings in March, 1990.

APPENDIX VI

Eugene J. Gillespie, M.D.
305 Sandwedge Lane
Alpharetta, Georgia 30201

Feb 4th, 1990

Dear Dr. Anderson,

Following our recent conversation I decided to put in writing what I said to you about how dramatically things have changed since AEtna took over.

During the time that I served as Medical Director, of the Georgia Medicare Part B for the Prudential Insurance Co. (beginning in 1977) we instructed internists of Georgia to bill for "comprehensive Physical" whenever it was performed.

I am distressed to learn that such billing is not now permissible under the new carrier, unless the doctor performs a lot of irrelevant or superfluous examinations. In other words, it's bad enough, for the new third party payers not to pay us for the work we do in a comprehensive physical. It's even worse for them to be telling us how to conduct the physical examination of our patients.

Sincerely,

Eugene J. Gillespie

Eugene J. Gillespie, M.D.

APPENDIX VII

RODNEY L. SMITH, M.D., P.C.
GENERAL PRACTICE OF MEDICINE
PRACTICE LIMITED TO ADULT MEDICINE
590 SOUTH ENOTA DRIVE, N.E.
GAINESVILLE, GEORGIA 30501
PHONE: (404) 534-1986

November 22, 1989

Aetna Life & Casualty Company
12052 Middleground Road
P.O. Box 3018
Savannah, Georgia 31402

Re: Statement Date 11/14/89 Medicare

To Whom It May Concern:

I hereby request review of your initial decision that my comprehensive evaluation of this patient should be downgraded to a limited level of service.

On 5/8/89, I spent about an hour working with going over his extensive list of problems relating to chronic congestive heart failure, hypertension, chronic atrial fibrillation, prostatism and arthritis, reviewing his medications and response to these medications. I performed complete physical examination and reassessed his status.

This 71 year old patient's condition has been unstable since I met him in the emergency room on 10/8/87. With great difficulty, he and I have worked to maintain some quality of life, as well as some longevity. Even with this level of care, he suffered acute myocardial infarction 3 months after the 5/8/89 evaluation.

In view of the complexity of this patient's problems, I fully expect that we will go through this process again. I do not agree with your decision and I question the validity of your mechanism for arriving at this decision. I would greatly appreciate your attention in reviewing this. In doing this, please note that I do not charge for comprehensive evaluation unless I perform comprehensive evaluation.

This patient lives on fixed income and has paid me for my efforts. My charge to him of $90 was quite reasonable for comprehensive evaluation. You now threaten to decrease allowable billing for this evaluation from $90 to $18. You would then reimburse the patient $14.40 for my service. You have suggested to the patient that he may be entitled to a refund of $75.60 within 30 days and that I may be subject to civil penalties.

If you will find a physician who can provide the quality of comprehensive service that this patient needs and can provide it for $18, please let me know, or perhaps the patient. I am certain that he would give some consideration to seeing such physician, especially if her practices in this country. If you cannot provide such information, it would appear that you do not really care about this patient's welfare or his access to quality health care.

I would appreciate the name of someone with whom I could discuss this further, preferably a physician.

If I can be of any help, please do not hesitate to contact me.

Sincerely,

Rodney L. Smith, M.D.

RLS:sc

cc: Patient

MAG

State Insurance Commissioner

Local Legislative Delegation

(Patient's name deleted to preserve confidentiality)

APPENDIX VIII

STEPHEN M. BARNETT, M.D.
AND
ROBERT W. POWERS, JR., M.D., P.C.
105 Collier Road, NW
Suite 1020
Atlanta, Georgia 30309

GENERAL AND VASCULAR SURGERY
Stephen M. Barnett, M.D., F.A.C.S.
Robert W. Powers, Jr., M.D.

December 7, 1989

Aetna - Medicare
P.O. Box 3018
12052 Middleground Road
Savannah, GA 31402-3018
ATTN: REVIEW DEPT.

RE:
#:
PHYSICIAN #: 247763959A
DATE OF SERVICE: 10/18/89

Dear Sir:

I would ask a review of the decision to down grade the consultation service performed on the above individual on the day of service. This down grading seems to have been an arbitrary decision and I am unaware that Medicare requested any additional information prior to this judgement.

The patient, Mr. , was admitted into Piedmont Hospital on 9/27/89 for the surgical treatment of a hiatal hernia. The patient had undergone this surgery but during his postoperative course developed a stroke. Our service was asked to evaluate this patient in regards to this stroke. My associate, Dr. Stephen Barnett, had seen the patient in the past in regards to arteriosclerotic problems in his lower extremities. I had not seen the patient in the past for carotid artery disease.

I provided a consultation then for a new problem on 10/19/89. That consultation included the acquisition of the patient's current history, a review of his past history in regards to cerebrovascular disease, a review of his complete hospital chart regarding his admission problem, current lab data, and diagnostic tests, and a complete physical exam relative to all arterial systems. I then overviewed his carotid arteriograms in a separate area of the hospital. I returned after doing so and had a conference with the patient and his wife. This was followed by a dictation of the formal consultation report which I enclose in his letter. Subsequent to the dictation of the consultation report, I had a conference with his referring physician and thoracic surgeon. This conference is not reflected on the consultation report but in order to qualify for an intermediate level of service, it is only necessary to have a formal patient family conference.

My consultation contains all the necessary requirements to qualify for an intermediate level of service. It was for this level of service that I submitted the charge for CPT code 90605. Medicare

PAGE 2
RE: C. GRANT
12/7/89

allowed an amount for a "less extensive procedure". I would ask that on review of this matter that a more appropriate allowance be provided.

Sincerely yours,

Robert W. Powers, MD
RWP/tlb

ENCLOSURE

cc: Cam Taylor, Medical Assoc. of GA

APPENDIX IX

EMORY UNIVERSITY SCHOOL OF MEDICINE
DIVISION OF OTOLARYNGOLOGY
1365 Clifton Road, N.E. Atlanta, Georgia 30322

John S. Turner, Jr., M.D.
Professor and Chief

Richard T. Jackson, Ph.D.
Research Director
Gerald S. Gussack, M.D.
Director of Residency Education

July 13, 1989

Mr. Paul Shanor
Executive Director
Medical Association of Georgia
938 Peachtree Street
Atlanta, Georgia 30309-3990

Dear Mr. Shanor:

Attached is a copy of a letter which you may find useful in our debates with Medicare on the gross errors which Aetna has committed.

For the past several months they have been denying coverage for patients with sensory neural hearing loss, stating that they did not cover this diagnosis since nothing could be done except to use a hearing aid. Obviously, there are many medical and surgical treatments for sensory neural hearing loss and as you will notice from Mr. Holland, the regional administrator of HCFA, a gross mistake was made. Many thousands of elderly Georgians have had to pay for hearing tests in the past few months since their claims to Medicare were disallowed. Hopefully, these patients will be repaid and hopefully all physicians will receive the corrected notice which Mr. Holland refers to in his letter.

If this type error is occurring in other specialties then there must be considerable mismanagement on Aetna's part.

Thank you for your assistance to us in this regard.

Sincerely,

John S. Turner Jr.

John S. Turner, Jr. M.D.
Professor and Chief

JST:dj
Enclosure

APPENDIX X

June 9, 1989

Refer to: DPO:BSB:WC
CONG (GA)

Honorable Sam Nunn
United States Senator
Suite 1700
75 Spring Street, S.W.
Atlanta, GA 30303

Dear Senator Nunn:

This is in response to your inquiry on behalf of John L. Turner, Jr., M.D., of Emory University. Doctor Turner wrote you concerning a letter from Aetna which indicated that hearing tests for conditions such as sensorineural hearing loss, are not covered by Medicare.

Doctor Turner is correct in pointing out Aetna's misinterpretation of Medicare coverage policy. We have already discussed this matter with Aetna and requested that they send out corrected notices to physicians. We appreciate Doctor Turner's calling this mistake to our attention.

Please contact Wayne Cole of my staff if you need further information.

Sincerely yours,

George R. Holland
Regional Administrator
Health Care Financing Administration

APPENDIX XI

ATLANTA VASCULAR DIAGNOSTIC LABORATORY

WW ORR DOCTORS BUILDING
478 PEACHTREE STREET, N.E.
SUITE 1110A
ATLANTA, GEORGIA 30308
(404) 659-1244

ALBERT WILDSTEIN, M.D., F.A.C.S.
MEDICAL DIRECTOR
CERTIFIED IN VASCULAR SURGERY
BY THE AMERICAN BOARD OF SURGERY

January 4, 1990

Alan Korn, M.D.
Vice President of Medical Affairs
Healthcare Compare
3200 Highland Avenue
Downers Grove, Illinois 60515-1223

Dear Dr. Korn:

Since January 1989, I have been actively trying to correct severe Medicare reimbursement problems relating to non-invasive vascular testing provided by my medical practice here in Atlanta, Georgia. I have met in person in Savannah, Georgia with Aetna representatives. I have contacted by telephone and in writing local, regional, and federal HCFA representatives. It has been made clear to me by the above mentioned parties that the issues I will describe for you are not a problem in any other state or region and are unique to Georgia. Aetna has made it clear to me that they are acting under Healthcare Compare direction in this matter.

As background, I am a Board Certified Vascular Surgeon in practice in Atlanta, Georgia. I serve as the Chairman of the Surgical Quality Assurance Committee for Emory University at Crawford Long Hospital and also am Georgia State Physician Reviewer for the Georgia Medical Care Foundation for Vascular Surgical Pre-Certification Hospital Reviews. Our medical practice has always been of a high-quality and has enjoyed an excellent relationship with our local Medicare Carrier until January of 1989 when Aetna and Healthcare Compare took over.

Since 1983, as a part of our medical practice and as a service to our referring doctors, we have performed out-patient non-invasive vascular testing on a physician referral only basis. We are participating providers with Medicare and accept assignment on all claims. In 1983, we invited Prudential Medicare to perform an on-site visit to work with us in arriving at responsible and reasonable allowances for those tests performed. Prudential did so, spending a full day observing our operations and since that time we have had no problems of significance until 1989.

Apparently Healthcare Compare has now made determinations regarding medical appropriateness of vascular testing and reimbursements procedures that are clearly medically

January 4, 1990

Alan Korn, M.D.
Page two

incorrect and which have had a profoundly severe effect on our operations.

I urge you to review the following issues:

1. VENOUS TESTING (CPT CODE 93950; CPT CODE 93960)

   VENOUS DOPPLER AND SEGMENTAL VENOUS PLETHYSMOGRAPHY FOR VENOUS OUTFLO AND CAPACITANCE ARE MEDICALLY NECESSARY TO MAKE THE ACCURATE DETERMINATION OF ACUTE DEEP VENOUS THROMBOSIS. EITHER TEST ALONE IS NOT SUFFICIENT TO MAKE THIS DIAGNOSIS. I ENCLOSE REPRESENTATIVE ARTICLES FROM THE STANDARD VASCULAR LITERATURE TO SUPPORT THIS STATEMENT.

Healthcare Compare has ruled that there is no medical necessity for segmental plethysmography (CPT 93960) when performed on the same day as venous Doppler (CPT 93950). This is clearly wrong and would severely jeopardize accuracy of results and the health of the patient. In fact, it would be arguable medical malpractice <u>not</u> to perform both Doppler and segmental plethysmography on the same day for the diagnosis of acute DVT. As always we have continued to perform both testing modalities since January of 1989 and have sustained major financial hardship in doing so as we have not reimbursed for VOVC (93960). I have enclosed some representative claims indicating that the denials have been on the basis of either the testing being performed on the same day as venous Doppler or the fact that the testing is "medically unnecessary."

You should be aware the proper use of venous non-invasive diagnostic testing by avoiding unnecessary hospital admission and associated risk of dye injections offers a major benefit to the patient and a major cost savings to Medicare. By making it impossible to sustain a quality out-patient testing service the outcome is a major loss to all parties involved.

Dr. Korn, I am very aware of the need to reduce Medicare expenditures and curb abusive practices. I am active in these roles both at Crawford Long Hospital and with the Georgia Medical Care Foundation. However "one must not throw out the baby with the bath water." In our situation, we have provided a quality service to referring doctors that has been

January 4, 1990

Alan Korn, M.D.
Page three

of benefit to the patients and has avoided needless hospitalization and associated costs and risks. Quality of service in this area is dependent on quality of personnel (our Technologists are all Registered Vascular Technologists) and equipment (our equipment is all high-quality duplex testing equipment) and can only be maintained with fair reimbursements. Our reimbursement levels are no higher now than they were in 1983.

I would urge you or your representatives to meet with me to review these issues. I furthermore would be happy to make myself available to you to help review HCFA Procedures and Guidelines. It is appropriate to ensure that quality equipment, quality technologists and qualified vascular physicians are involved in providing these services.

I have enclosed for your review medical documentation for venous procedures and selected correspondence. I would encourage you to contact me so that we maybe sure to have an agreeable policy that will avoid future problems especially as they relate to cerebrovascular testing (CPT Code 93870; 93860; 93850), and arterial testing (CPT Code 93910). I have also notified several interested parties by copy of this letter so that they may stay informed as this situation develops. They are all actively involved in helping to resolve these issues.

I look forward to your prompt response.

Best regards,

Albert Wildstein, M.D., F.A.C.S.
Certified in Vascular Surgery
By The American Board of Surgery

AW/sd

APPENDIX XII

CHAPPELL A. COLLINS, JR., M.D.
810 THIRTEENTH AVENUE
ALBANY, GEORGIA 31701
TELEPHONE (912) 883-1208

July 12, 1989

AETNA Life and Casualty Company
12052 Middle Brown Road
P. O. Box 3018
Savannah, Ga. 31402

RE: HEALTH INSURANCE CONTROL #

Dear Sirs:

I am writing in regards to denial of payment for services provided to my patient, from January 1 through February 20, 1989. She was hospitalized from November 17, 1988 until discharged to the nursing home on February 20, 1989. My services were paid through December 31, 1988 by Prudential. All my services have been denied since you have taken over from Prudential. I cannot understand this denial since the patient, on January 1, 1989, remained in the Intensive Care Unit on a respirator and it wasn't until January 29, 1989 that she was taken off the respirator and placed on a T-tube. Her tracheostomy was not plugged until February 4, 1989. She was finally moved to a room on the floor on February 7, 1989 and was able to be transferred to the nursing home on February 20, 1989 when a bed became available. According to my office manager, your reviewer was concerned about the frequency of visits and did not feel it medically necessary for daily visits. Let me assure you that any patient I admit to a hospital will be visited daily by me or the physician covering my responsibilities. A progress note was written every day as can be noted in the progress notes section of the chart. I admitted the patient and I discharged the patient, therefore I was responsible for her care the entire length of her hospitalization. I do not think anyone knowledgeable in medical care reviewed this chart. The bad name Aetna has earned is obviously based on such denials as this. It is hard for me to comprehend that anyone would question medical necessity for services submitted for someone confined to an Intensive Care Unit on a respirator.

Please consider this letter as a request for reconsideration of the claims submitted for services rendered to

Respectfully submitted,

C. A. Collins, Jr., M. D.

cc: Senator Sam Nunn
Senator Wytch Fowler
Congressman Charles Hatcher

President MAG

Enclosure

APPENDIX XIII

PHYSICIANS LETTERS DATED JANUARY 2, 1990 - FEBRUARY 22, 1990
CONCERNING MEDICARE/AETNA COMPLAINTS

Ref. #	Date	Physician	Sent to:	Problem Experienced
1	1-2-90	Thomas J. Anderson, Jr., MD Internal Medicine	AEtna Susan Stallings	-denial of all payments
2	1-2-90	Paul H. Liebman, MD, PC Internal Medicine	MAG	-incorrect payment
3	1-2-90	Pierce K. Dixon, MD General Surgery	AEtna	-undercharge
4	1-3-90	Institute for Rad. Ther.	MAG	-denial of payments
5	1-3-90	J. Harris Dew, MD General Surgery	AEtna	-repeat letters requesting payment to patient by physician even with waivors sent
6	1-4-90	Albert Wildstein, MD, FACS Vascular Surgery	MAG re: Allan Korn (HCC)	-non-invasive vascular testing denials
7	1-5-90	Ken Dixon, MD General Surgery	AEtna	-incorrect MAAC's
8	1-9-90	Robert M. Patton, MD, PC Cardiology	MAG	-nonpayment of interest -denial or inconsistency of payments
9	1-10-90	Donald B. Waters, MD Family Practice	AEtna	-downcoding
10	1-12-90	Raymond A. Young, MD, FACC Interventional Cardiology	AEtna	-checks being sent to another facility and AEtna will not pay interest on the $26,000+
11	1-15-90	James S. Blanc, MD Thoracic Surgery	AEtna	-was not paid for service on 1-15-90 but was paid for same service on 11-17-89
12	1-16-90	Paul C. Cronce, MD Dermatology	AEtna	-undercharge and combining of claim charges by AEtna -miscoding by AEtna, incorrect payments
13	1-16-90	Ken Dixon, MD General Surgery	AEtna	-miscoding by AEtna and underpayment

Page 2

14	1-17-90	Charles E. Wills, Jr., MD Family Practice	AEtna Roger Pattee	-request for hearing denied
15	1-17-90	Paul H. Liebman, MD, PC Internal Medicine	AEtna	-improper denial of payments
16	1-19-90	David C. Bosshardt, MD Internal Medicine	AEtna	-denial of procedure
17	1-23-90	Cardiovascular Consultants	MAG	-no response to resubmittals, some as far back as Feb., March, April of 1989 -incorrect profile with Travelers Medicare
18	1-24-90	James W. Estes, MD, FACS Vascular Surgery	MAG	-denials -improper reimbursement; inconsistencies in vascular testing payments
19	1-25-90	John S. Kennedy, MD General Surgery	AEtna	-incorrect payments -customary profile incorrect
20	1-27-90	Richard C. Smith, MD Ted A. Scoggins, MD Family Practice	AEtna	-42 unprocessed claims totaling $5,790 from 8-88 through 11-89
21	1-27-90	Charles E. Wills, Jr., MD Family Practice	MAG	-severe reduction taken on unassigned claim
22	1-29-90	Robert W. Powers, MD, PC General Surgery	AEtna	-invalid CPT code charged by AEtna when only one available
23	1-29-90	Michael Di Cristina, MD, PC Internal Medicine	AEtna	-payment not received for over a year
24	1-29-90	Cardiovascular Consultants	MAG	-claims resubmittals with no response from AEtna
25	1-31-90	Michael J. Maloney, MD Pediatrics	MAG	-wrote Medicare 3-14-89 with 1 simple questions and it took until 1-25-90 to get an answer
26	2-2-90	John S. Kennedy, MD General Surgery	AEtna	-incorrect allowed amount and payment
27	2-2-90	Robert W. Powers, MD, PC General Surgery	AEtna	-downpayment on claim with modifyer
28	2-2-90	Cardiovascular Consultants	AEtna	-downpayments on secondary payor claims

29	2-2-90	Robert W. Powers, MD, PC General Surgery	AEtna Sarah Phillips	-refusal of claim payment due to AEtna's error in date of death
30	2-2-90	Stephen M. Barnett, MD General Surgery	AEtna	-error in reimbursement amounts from improper bundling of claims
31	2-5-90	William S. Hagler, MD Ophthalmology	Senator Sam Nunn	-denial of payment for routine eye exam when involved malignant melanoma
32	2-5-90	Muscogee Co. Med. Society Barbara Dent	MAG	-problem with lab service who have free standing surgi-centers
33	2-6-90	E.M. Molnar, MD, PC General Surgery	AEtna Catherine Stevens	-AEtna requesting refund - which was already sent by Dr.
34	2-8-90	Philip R. Saleeby, MD, PC Internal Medicine	MAG	-follow-up consultations denied
35	2-9-90	R. Paul Crank, Jr., MD Cardiology	AEtna	-denial of comprehensive service
36	2-9-90	Charlotte Van Hoozier, MD Obstetrics & Gynecology	MAG	-denial of payment
37	2-12-90	Darrell R. Caudill, MD, PC Cardiovascular and Thoracic Surgery	MAG	-denials
38	2-13-90	Thomas W. Davis, MD Family Practice	AEtna	-miscoding by AEtna and incorrect payments
39	2-14-90	David C. Bosshardt, MD Internal Medicine	AEtna	-unpaid services
40	2-20-90	Paul A. Kirschbaum, MD Internal Medicine & Cardiovascular Diseases	MAG	-concurrent denials taken with no apparent justification
41	2-14-90	Carl C. Jones, Jr., MD	AEtna	-incorrect MAAC's
42	1-30-90	[patient complaint]	MAG	-denial of payment because doctor did not take assignment
43	2-19-90	William H. Jarrett, II, MD Ophthalmology	AEtna	-AEtna requested additional information relating to services provided following accident
44	2-20-90	Patient	AEtna	-complicated procedure paid as routine

45	2-20-90	Joseph J. Nichols, MD Colon & Rectal Surgery	AEtna	-follow-up Sigmoidoscopy denied as routine check-up
46	2-2-90	Earl T. Martin, MD Family Practice	Congressman Rowland	-AEtna changing procedure codes to effect lower payment
47	2-22-90	P.C. Cronce, MD Dermatology	AEtna	-continuing erroneous payments
48	2-21-90	Ronald P. Roper, MD Urology	MAG	-lower reimbursements for cost of chemotherapy agent Thiotepa
49	2-26-90	E. M. Molnar, MD General Surgery	AEtna	-AEtna questions "medical necessity"
50	2-27-90	Charles E. Bohler, MD, PC Family Practice	MAG	-have not received payments for the 2nd & 3rd quarter of 1989

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APPENDIX XIV

Medical Association of Georgia

938 PEACHTREE STREET, N. E.
ATLANTA, GEORGIA 30309

OFFICE OF THE PRESIDENT

December 1, 1989

Robert S. Champagne, Director
Medicare Administration
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Champagne:

One of our physician members has alerted us to an error that we consider to be the most grievous in the series of blunders in Aetna/Medicare's short but troublesome history in attempting to serve the people of Georgia. Once again, the physicians and patients of Georgia have been assaulted by the incompetent processing of claims by inept AEtna staff people.

The Medical Association of Georgia has learned that during AEtna's attempt to deduct the 2.092% required to achieve the Gramm-Rudman reduction for fiscal year 1990, physicians clinical lab charges for a 30 day period during October and November of 1989, were actually reduced by 20% of the reimbursed amount.

Ms. Stallings' representative, Ms. Tee, has confirmed this error in a phone conversation with an MAG staff person. The Savannah office apparently has known about this error for at least one, or possibly two weeks, yet has made no attempt to contact those parties effected by their ineptitude. Neither AEtna/Medicare nor Health Care Financing Administration has made any attempt whatsoever to get in touch with the Medical Association of Georgia or to communicate directly with physicians as to the existence of this computer reimbursement error. Furthermore, Ms. Tee failed to offer any satisfactory remedy for this significant and far-reaching mistake. Rather, AEtna is abdicating its responsibility to provide a remedy, forcing physicians to conduct their own claim investigation and to resubmit previous charges for corrected reimbursements.

This response to an error of such magnitude by your personnel is unacceptable.

The Medical Association of Georgia asks for an immediate corrective action plan which includes the necessary financial review and computer analysis for physicians who have been denied their proper reimbursement, and prompt repayments of all amounts owed.

We will appreciate your formal response within two weeks.

Sincerely,

Joe L. Nettles, M.D.
President
Medical Association of Georgia

JLN/tv

CHARLES EMORY BOHLER, M.D., P.C.
P. O. BOX 8
BROOKLET, GEORGIA 30415
PHONE (912) 842-2107

APPENDIX XV

February 27, 1990

Georgia Medical Association
938 Peachtree St. N. E.
Atlanta, Georgia 30309

Attention: Paul Sharor

We mailed claims for Medicare-Medicaid patients for the second quarter of 1989 the first of July 1989. When we were in the process of getting ready to send third quarter we realized we had not been paid by Medicaid for the second quarter. We then called Medicare and they did not know what happened. We called Medicaid they said they had never received the claims from Medicare. Evidently their computer did not pick up when Medicare sent and they (caid) could not go back and pick up the claims and that we would have to redo all claims with a crossover and mail them directly to Medicaid; which we did (we have been paid for this now). However in checking now- we have not been paid for the third quarter 1989.

I personally spoke with Mr. Aaron Johnson yesterday and he promised to find out what the problem is. Mr. Johnson's people (Georgia Medicaid) called back and said the problem definately is with Medicare (Aetna-Savannah). We called them (Medicare). They have no excuse and no reason for Medicaid not getting my claim tapes. They promised to "check into it."

Now we must spend extra expensive time re-doing claims so that I can receive the minimal fees that I have earned working for Medicare-Medicaid.

It's disgusting and I can understand why so many of my colleagues no longer care for Medicare-Medicaid patients.

The basic problem is the gross negligence and indifference of Aetna Insurance Company.

Sincerely,

C. E. Bohler, M. D.

Sec. 1869, (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A or part B, and any other determination with respect to a claim for benefits under part A or a claim for benefits with respect to home health services under part B shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to --

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965.

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818,

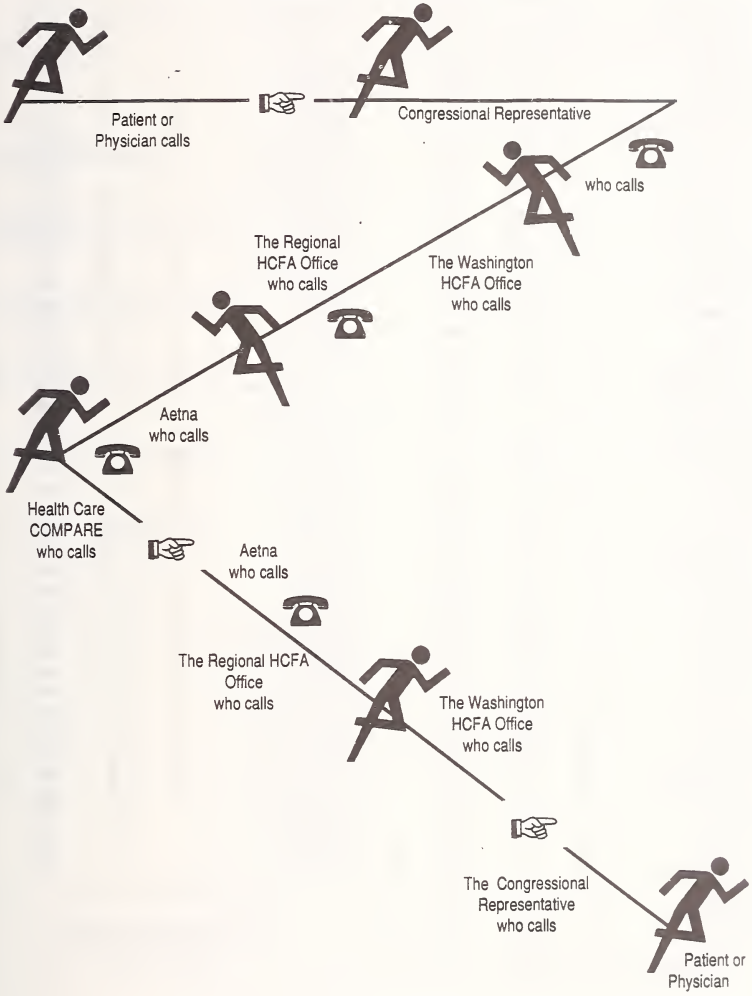
(C) the amount of benefits under part A or part B (including a determination where such amount is determined to be zero), or

(D) any other denial (other than part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. In addition to such other remedies they may have in their own right, and, upon a showing that matters complained of have been brought to the party involved for corrective action without regard to any requirement for a hearing described in subsection 1842(b)(3)(C), persons furnishing services or items to beneficiaries may represent such individuals seeking hearings under §205(b) and judicial review under §205(g), in the name of the beneficiaries or in their own names, with respect to the failure of entities holding contracts and subcontracts to administer the payment of benefits as required by Part A or Part B and regulations, rulings, policies and instructions promulgated thereunder, and by the contracts and subcontracts, where the conduct complained of gives rise to the right to a hearing by two or more individuals under subsections (b)(1)(C) or (D). Contractors and subcontractors engaging in conduct found to be contrary to their contractual obligations,

including compliance with regulations, rulings, policies and instructions shall give effect to such findings not only with respect to the claims subject to the hearing but for all similar claims. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation. If an action is successfully maintained, in whole or in part, against a contractor or subcontractor with respect to administration of the contract, the Secretary shall award such interest, costs and legal fees to be born by the contractor or subcontractor as shall be deemed appropriate.

HOW A MEDICARE QUESTION IS ANSWERED IN GEORGIA



FY 1989 DEFRA RANKING WORKSHEET

MEDICARE PART A INTERMEDIARIES	EFFICIENCY RATES 1988 CPEP	1989 CPEP	DEFRA POINTS	RANK
MS Jackson	99	100	498	1
FL Jacksonville	99	99	495	2
NE Omaha	99	99	495	
SC Columbia	99	99	495	
@ Aetna PA	99	99	495	
@ Mutual of Omaha	99	99	496	
MA Boston	98	99	493	7
NC Durham	98	99	493	
IA Sioux City	99	98	492	9
CT North Haven	97	99	491	10
GA Atlanta	97	99	491	
UT Salt Lake City	97	99	491	
@ Aetna CT	97	99	491	
AZ Phoenix	96	98	490	14
TN Chattanooga	98	98	490	
WV Charleston	98	98	490	
IL Chicago	97	98	488	17
MT Helena	97	98	488	
ND Fargo	97	98	488	
OH Cincinnati	97	98	488	
PA Philadelphia	97	98	488	
MO St. Louis	98	97	487	22
VA Richmond	98	97	487	
AR Little Rock	96	98	486	24
KY Louisville	96	98	486	
MD Baltimore	94	99	485	26
NJ Newark	94	99	485	
MN St. Paul	95	98	484	28
NY New York	95	98	484	
@ Aetna IL	95	98	484	
DE Wilmington	96	97	483	31
LA Baton Rouge	96	97	483	
@ Aetna CA	93	99	483	
@ Aetna FL	96	97	483	
IN Indianapolis	97	96	482	35
OK Tulsa	97	96	482	
PA Pittsburgh	95	97	481	37
ME Portland	94	97	479	38
WA Seattle	97	95	479	
WY Cheyenne	97	95	479	
IA Des Moines	93	97	477	41
HI Honolulu	92	97	475	42
NH Concord	95	95	475	
WS Milwaukee	95	95	475	
@ Cooperative PR	92	97	475	
AL Birmingham	93	96	474	46
MI Detroit	93	96	474	
TX Dallas	96	94	474	
KS Topeka	95	94	472	49
CA Los Angeles	91	96	470	50
OR Portland	96	91	465	51
@ Travelers	93	93	466	
NM Albuquerque	94	91	461	53
RI Providence	90	92	456	54
CO Denver	94	88	452	55
AVERAGES	95.9	96.9		

MEDICARE PART B INTERMEDIARIES	EFFICIENCY RATES 1988 CPEP	1989 CPEP	DEFRA POINTS	RANK
@ GHI NY	97	98	488	1
MD Baltimore	95	99	487	2
ND Fargo	96	97	483	3
@ Equicor ID	96	95	481	4
MI Detroit	94	97	479	5
SC Columbia	93	97	477	6
PR San Juan	94	96	476	7
UT Salt Lake City	94	96	476	
@ Travelers VA	91	96	476	
MN St. Paul	95	95	475	10
@ General American	95	95	475	
MA Boston	93	96	474	12
TX Dallas	93	96	474	
@ Travelers MN	93	96	474	
IL Chicago (Marion)	94	95	473	15
NY Buffalo	94	95	473	
@ Aetna HI	94	95	473	
@ Aetna OR	94	95	473	
AR Little Rock	95	94	472	19
RI Providence	91	96	470	20
CA San Francisco	92	95	469	21
MT Helena	95	93	469	
@ Nationwide OH	92	96	469	
AL Birmingham	93	94	468	24
@ Aetna NM	93	94	468	
@ WPS-WI	90	96	468	
IA Des Moines	91	95	467	27
IN Indianapolis	88	97	487	
KY Lexington	93	93	465	29
@ Travelers CT	90	95	465	
@ Aetna	91	94	464	31
@ Travelers MS	88	96	464	
KS Topeka	95	91	463	33
PA Camp Hill	92	93	463	
MA Tri-State	90	93	459	35
@ Occidental CA	96	87	453	36
AR Little Rock (LA)	94	88	452	37
@ Equicor TN	93	88	450	38
CO Denver	92	88	448	39
NY New York	93	86	444	40
WA Wash Phys Svc	92	85	439	41
@ Aetna AZ-NV	92	85	439	
@Equicor WY	91	84	434	43
MO Kansas City	92	83	433	44
FL Jacksonville	93	68	390	45
PA Camp Hill (NJ)		89	267	
@ Equicor NC		81	243	
KS Topeka (NE)		79	237	
@ Aetna GA		64	192	

Bottom 20th Percentile

FY 88 is weighted at 40% (x2), and FY 89 is weighted at 60% (x3).

93.0 91.6

MEDICARE SERVICE CLAIMS DENIED OR REDUCED

JANUARY-MAY 1989

TYPE OF CASE	NUMBER ANSWERING THAT THIS OCCURS FREQUENTLY	
	DENIED	DOWNCODED
CONCURRENT CARE	61%	46%
COMPREHENSIVE VISITS	40%	75%
INITIAL HOSPITAL VISITS	23%	67%
DAILY HOSPITAL VISITS	14%	31%
DIAGNOSTIC PROCEDURE	24%	27%
MEDICAL CONSULTANTS	27%	67%

Mr. WAXMAN. Dr. Copeland.

STATEMENT OF ROBERT B. COPELAND

Mr. COPELAND. Thank you, Chairman Waxman, Mr. Rowland.

I want to provide you with some insight into what is going on with our patients and our medical care delivery from the eyes of a practicing small town physician.

I appreciate very much the opportunity to be here today. Let me point out that there——

Mr. WAXMAN. If you would speak into the microphone, just to be sure to get it on the record.

Mr. COPELAND. There is a formal American College of Physicians' statement for the record. What I would like to talk to you about is things that I personally feel very much sensitive to.

I am a practicing physician in a small town, 25,000 people, and my practice is about 75 percent Medicare. I have had 100 percent assignment, as have my two partners, for years, had a contract with Medicare from the time those came along. My hospital is the only hospital in the county and it is designated by Medicare as a rural referral center.

I have been in practice there for 22½ years, coming after I finished internal medicine and cardiology training at Harvard Medical School and the Massachusetts General Hospital in Boston.

I am very interested in geriatrics and I am board certified in geriatrics. I have had exposure to the English National Health Service, working as a visiting fellow at the Royal Free Hospital in London and while maintaining a full time practice, I have stayed involved in medical education and medical leadership.

Working with Federal programs is not new with me. I worked—was very much involved with the HSA's here in Atlanta several years ago. I am currently on the Institute of Medicine and National Academy of Science's task force looking at assessment and assurance of quality in Medicare. And I must say, I am very concerned about what is going on, not only in Georgia but its implications qualitywise for the country.

What we need, I recognize very clearly, is sound reforms in a number of areas. Reforms that are databased, are reasonable and are presented by people with skill and done effectively. Certainly there are areas of reform that are needed in access and quality as well as in cost and certainly I recognize, as we all have to, that there are physician abuses. I think those physician abuses ought to be dealt with for what they are though, Mr. Chairman, and I do not think that those hardworking, caring, competent and fair-charging physicians in Georgia should be continuously painted with the black brush of HealthCare COMPARE or Aetna as all being a bunch of crooks.

In can tell you, despite what you are going to hear today no doubt, that the problem in Georgia is not fixed. Things are not better. The problem is destructive, it is continuing and the most important thing is the future influence, the impact on quality care for Medicare enrollees. We will all be Medicare enrollees one of these days. Those quality care delivery issues are far, far greater than the impact on physicians' income, although the latter is what

we usually hear about from the people who are defending the current mess.

If you look back, from my perspective, the problems really basically are not just transition alone, they were a failure to perceive and to satisfy the very real need of informing physicians, even though it is my understanding that the HealthCare COMPARE contract called for that specifically. There was no effective—in our town there certainly was not and my colleagues around the State tell me the same thing—there was no effective communication or involvement, all those buzz words that—on the part of HealthCare COMPARE.

My letter that is referred to in here, the special letter to Georgia physicians, came to me on April 23 and the issues were comprehensive codes being down—I have been told by Allen Corn, Vice President of HealthCare COMPARE and by Bob Becker, the Chairman of the company, that if there is no downcoding other than as justified by contemporaneous documentation. I can tell you, Mr. Chairman, that is a bunch of bull. I can show you with my own experience of codes being cut from comprehensive, past extended, past intermediate and down to limited, over and over again. And then finally after taking the third appeal step, then being recognized for what they were. We have not been dealt with straight by the leadership of HealthCare COMPARE.

I want to show you one that Representative Rowland will certainly identify with, of a patient about 70 years old, very complicated heart disease, on chemotherapy, on 100 milligrams of cortisone a day. He calls me up one day with abdominal pain. We worked him into a full schedule, saw him, was concerned about whether he had a big lymph node or where he had an incarcerated hernia, got a surgeon to see him the same day and it turned out to be a hernia and he was operated on the next day.

But when my code came back and was disallowed for concurrent care because another physician—I do not think it is too much to ask a review company to be able to separate a surgeon from an internist—but another physician had been paid for seeing the person. So by the time my office appealed it twice and I got around to appealing it, the patient brings me himself—comes by with a letter he has gotten, most incredible mish-mash of craziness I have ever seen. Among other things, it says to him that the services I provided were not reasonable nor necessary and that if he had paid anything, then I owed him that back.

Well eventually when that was appealed, it finally came around that my bill that Medicare was responsible for was—they approved for $19.80 and then to top it all off, the final letter I got said well they were allowing the charge but they are then cutting in controversy $12.24, so that that would not be paid me until there was $100 or more in controversy. You make sense of that.

In closing, I want to say to you that in addition to the recommendations made in our paper, I would like to speak for 1,150 internists in Georgia and say that we are not nearly as gentle as Representative Lindsay Thomas. We are ready to see them go. I think they have used up whatever good will they had, as physicians they were met with good will when they came here, they simply used it

up by not being fair, not being square, not being consistent. The damage is irreversible.

The other thing we would like to very strongly urge you is to set up a work group with the key players so we can get on with things. A lot of these have national implication for things that need to be done, but they are too important to be left here. What really has happened is that we have talked and talked and talked for 14 months and the key players are not even here today. They do not even have enough respect for your committee for Dr. Robert Becker or Dr. Allen Corn to even be here. I would hope that you would set up a work group with these key players and somehow maybe people from your point of view can get on with some of the things that need to be done.

Thank you very much.

[Testimony resumes on p. 114.]

[The prepared statement of Dr. Copeland follows:]

STATEMENT OF

THE AMERICAN COLLEGE OF PHYSICIANS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HOUSE ENERGY AND COMMERCE

March 5, 1990

The American College of Physicians appreciates this opportunity to appear before you today to discuss Medicare Part B carrier issues. We would like to discuss the specific difficulties that are being experienced by internists in Georgia and comment on the larger national policy implications of these problems. With a membership of 67,000 general internists and subspecialists, the College is the largest medical specialty society in the country. Our Georgia chapter includes over 1100 internists.

I am Robert B. Copeland, the ACP Governor for the state of Georgia, and an internist in private practice in LaGrange. I am also Clinical Professor of Medicine at Emory University, and Clinical Professor of Medicine, Cardiology, University of Alabama in Birmingham. Accompanying me today is Deborah M. Prout, Director of Public Policy for the College and of our Washington office.

INTRODUCTION:

Today, I would like to briefly highlight some of the problems that have been experienced by internists in Georgia over the past 14 months and comment on actions that we believe would be helpful for resolving this situation in the short-term. However, I want to emphasize strongly that the events in Georgia, although in some instances specifically stemming from the transition between carriers and the ongoing pilot project with HealthCare COMPARE, are also emblematic of the type of problems increasingly being faced by internists throughout the country.

The ACP believes that the events in Georgia are illustrative of the critical need to continue the reform efforts begun by this committee in its work on physician payment. On a larger national scale, events in Georgia are a compelling reminder of the need for: reforming our utilization control methods and procedures; moving ahead with reform of the coding system; and addressing the serious problem of administrative costs in our present health care system and the attendant administrative burdens felt by patients and their physicians.

In addition, events in Georgia raise questions about the accountability of the Health Care Financing Administration, and of carriers and those engaged in utilization review. We believe that the situation would not have reached the present level of discomfort if appropriate attention had been paid by HCFA, by Aetna, and by Health Care COMPARE to their responsibilities for meaningful and productive interchange with the physician community. But, in this particular

instance there has seemed to be little incentive on the part of these key players to attempt to resolve problems and to be appropriately responsive to providers. In fact, there has been every incentive for them to attempt to minimize the complaints from physicians and beneficiaries in the interests of successfully completing this pilot project and expanding these review activities to other jurisdictions.

Consequently, the situation in Georgia raises profound questions about whether appropriate safeguards exist in the system to assure that ulization review efforts do not become a tool for wholesale cost containment and budget savings exercises as opposed to their proper role in assuring that appropriate services are delivered to beneficiaries.

Additionally, we believe that as we look towards reform of our health care system, we must examine the role of for-profit enterprises in review and other activities and ask serious questions about the inherent conflicts that may well exist for such enterprises.

In short, there are a host of issues raised by the situation in Georgia that relate to: (1) rectifying problems and ensuring appropriate behavior and sufficient accountability on the part of HCFA, Aetna, and HealthCare COMPARE in the immediate future; (2) the implications of the Aetna/Health Care COMPARE pilot project, its protocol and how it will and should be evaluated; and (3) ongoing and urgently needed longer-term reform of the health care system throughout the country.

BACKGROUND ON THE PROBLEM:

The specific difficulties in Georgia appear to have their origins in the transition in late 1988 and early 1989 from one Medicare carrier to another -- from Prudential to Aetna Life Insurance Company. As you will no doubt learn from the Aetna representatives present at this hearing, difficulties experienced with that transition resulted in significant backlogs of claims and slowing of payments for services. In late Feburary 1989 there was a backlog of over 800,000 claims. There were physicians within the Georgia chapter of the College who went several months without receiving payment for services that they had provided to Medicare beneficiaries. For some private practitioners the payment slowdown was sufficient to force them to secure personal loans to maintain their practices.

The problems that we wish to discuss today are not problems of transition. Instead it is the issue of approach to utilization control.

As you know, the Health Care Financing Administration is supporting a pilot project in the state of Georgia that required Aetna, as the Medicare carrier, to subcontract with HealthCare COMPARE Corporation of Downers Grove, Illinois, a for-profit corporation, for the provision of medical review and utilization control services (MR/UR). It is our understanding that under the terms of the subcontract the evaluation of the pilot project will "compare the relative advantages and disadvantages of subcontracting MR/UR and to evaluate whether increased flexibility and funding result in a "better"

MR/UR program." It is absolutely unclear in any documents that we have reviewed what the criteria is for a "better" MR/UR program.

Early on in the relationship between Aetna, HealthCare COMPARE, and the physician community, a number of internists began to report dramatic changes in the manner in which claims for evaluation and management services -- the basic primary care and diganostic services of internal medicine -- were being handled. It appeared that patient visits classified by the practitioner as "comprehensive visits" were being automatically downcoded to a lesser level of care, most frequently all the way to a "limited visit" and paid accordingly. This three-story downcoding if you will, bypassing the code levels of "intermediate" and "extended", represents a significant reduction in the assessment of the complexity of the clinical services provided that does not comport with the views of the clinicians on the front-line of patient care delivery, and does not comport with past experience in Georgia.

This dramatic change in how services were being reviewed and paid for was a direct departure from past experience with Prudential. It caused, and continues to cause, significant confusion, frustration, and anger, within the internal medicine community and with our patients. It became necessary for internists to appeal these downcoded visits and to provide additional documentation, this created in turn a backlog in the adjudication of claims for comprehensive visits and imposed a significant paperwork burden on individual internists and their office staffs. Anger with this situation touched off a series of exchanges and

meetings between representatives of Aetna, HealthCare COMPARE, and physicians throughout the first nine months of 1989. It was clear that the review criteria being used by HealthCare COMPARE was different either in fact or in application from that which had been used in the state of Georgia in the past.

HealthCare COMPARE stated at the time that they were using a review screen based upon a standard of one comprehensive visit in the clinician's lifetime relationship with the patient. This standard did not, and does not, comport with the accepted medical practice; however, the burden was placed on the physician to document the necessity of any service which fell outside of this arbitrary standard.

Despite the critical need to reach a common understanding of and consensus on the screens that would be used to review physician services, it was not until August, 1989 that HealthCare COMPARE -- having agreed that their existing standard was in error -- provided a draft of a revised Comprehensive Service documentation requirement. Despite assurances by key HealthCare COMPARE staff that revisions would be forthcoming in a matter of weeks, it was not until December, 1989 that this document was finalized -- fully a year after the start of the problem.

However, even today, long after admissions from HealthCare COMPARE that mistakes had been made in the screens that were applied to comprehensive visits throughout a significant portion of 1989, there is no adequate mechanism for redress on behalf of those individuals who

provided services that were inappropriately downcoded. Despite assurances from Dr. Robert Becker in November that claims denied or downcoded as a result of inaccuracies in HCC's operational definition of comprehensive services would be identified by computer and adjusted, we have subsequently been informed by the Health Care Financing Administration that each such claim must be individually appealed by the physician. This represents a virtually impossible procedural task for practicing physicians, and its impossibility will allow HCFA, Aetna, and HealthCare COMPARE to claim significant cost savings in the Medicare program.

Data presented by HCFA indicates that between January and June, 1989, 22.8% of "comprehensive services" delivered by internal medicine were suspended for review; 82.1% of these were then reduced at an average reduction per service of $35.82. This achieved a budgetary savings of $960,571 during a six month period for internal medicine alone. For all specialties combined the savings was $1,945,505 during the six months period. Now we have a direct admission that certain of these decisions were in error, but no realistic hope of recovering funds inappropriately denied.

Problems are also being experienced in the application of review screens for "concurrent care" and for "consultations." Again, despite numerous commitments to resolving these problems, little progress has been made. In the meantime, individual internists must provide further documentation in defense of their claims for these services, resulting in a significant additional paperwork burden. For some physicians, the

requirements for further documentation are so time consuming that they do not pursue the matter. In all such instances, HealthCare COMPARE and Aetna succeed in reducing Medicare payouts. As the cynicism grows within the physician community, many believe that HealthCare COMPARE, Aetna, and HCFA are strategically relying upon this mounting physician frustration in order to obtain cost savings.

There also appear to be serious technical errors in the Maximum Allowable Actual Charge (MAAC) levels for selected services, in particular for extended and intermediate visits. For many physicians this means that these levels of service are paid at rates substantially below comprehensive visits, totally out of line with previous practices. To date, HealthCare COMPARE and Aetna have indicated that achieving corrections and adjustments in payment levels that do not comport with even common sense analysis of reasonableness is a problem that the medical community must resolve with HCFA. We view this as a lack of corporate commitment to creating a payment system that functions fairly and effectively.

The cavalier attitude of HealthCare COMPARE and Aetna towards prompt resolution of critical issues has sown seeds of mistrust and frustration. The manner in which clinical codes have been interpreted to the financial benefit of the carrier and reviewer have heightened the cynical outlook of many physicians, and this has been further compounded by the unwillingness to make proper restitution, even in the face of admitted error on the part of HealthCare COMPARE.

POLICY IMPLICATIONS OF GEORGIA EXPERIENCE:

As indicated at the outset of our statement, much of what has been and is occuring in Georgia is emblematic of increasing problems in the system throughout the country. We would strongly urge that as the committee continues to consider the situation with respect to Georgia that we attempt to work towards solutions that will benefit the Medicare program on a national level.

The experiences in Georgia point to the need for short-term and long-term reforms. First, there must be mechanisms to assure appropriate responsiveness to questions and concerns raised by the physician community. In Georgia, profound disagreements with respect to the clinical and analytical bases for reviewer's practices have been allowed to remain unresolved for fourteen months. Meanwhile, it becomes increasingly difficult for physicians to deliver primary care services as their time is spent responding to documentation and paperwork demands, and preparing appeals on services denied or downcoded. Patients lives are made more difficult in the confusion over changing rules, denied claims and altered payment levels.

Second, these paperwork and documentation issues must be addressed, both in the short-term in Georgia, and over the longer-term for the system at large. As this committee knows, the system presently suffers from billions of dollars spent on administrative tasks; some of this money could be returned to patient care with proper streamlining of the system. In addition, present documentation requirements of many

carriers and reviewers, including those of HealthCare COMPARE, raise serious confidentiality and privacy concerns for patients. The College is increasingly concerned about the potential for misuse of confidential patient information requested by carriers for claims adjudication.

Third, as we have testifed before this committee before, major reform is needed in our approach to utilization review. At present, such review operates in a punitive fashion that frequently treats physicians as crooks and patient-physician encounters as fraudulent until proven otherwise. Recent hyperbolic statements in the Georgia press by HCFA and others that imply wholesale abuse and fraud in the system, have not contributed to a positive climate. The failures in the approach taken so far in Georgia underscore the need for a fundamentally different approach and attitude towards monitoring service delivery in the future.

We have stressed in our statements before the Physician Payment Review Commission that new models for utilization review are a critical next task for all of us concerned with improving the health care system. We must move beyond the punitive approach of the present to a system that better recognizes the fact that the overwhelming majority of internists provide appropriate medical services. Use of an approach which looks at patterns of practice rather than each individual physician-patient transaction would be a significant improvement. Innovative approaches based upon "continuous improvement models" also require study and evaluation.

Experiences in Georgia point to the need to move foward as quickly as possible with reform of the coding system, particularly for evaluation and management services. HealthCare COMPARE appears to be relying on the ambiguity of the present coding system in order to achieve cost savings for the Medicare program. As you know, coding reform has already been outlined as a remaining task in fully implementing a fee schedule based on a resource-based relative value scale. However, the price being paid in confusion, ambiguity, and misinterpretation of existing codes, and the possibility for inappropriate denials of payment for services, places a high premium on completing the coding reform task as quickly as is feasible.

RECOMMENDATIONS FOR SHORT-TERM ACTIONS:

Finally, we would urge a series of immediate, short-term remedies for the specific situation in Georgia.

We urge Congressional scrutiny of the protocol for the Georgia pilot project, the criteria under which it will be evaluated, and the circumstances surrounding the awarding of a contract to HealthCare COMPARE. We are deeply troubled that this subcontract appears to have been renewed at the end of the initial year without discussion or evaluation and in the face of continuing serious problems in the carrying out of the review functions.

We would urge that steps be taken to ensure that contract performance standards and performance standards for carriers better

recognize the need for meaningful and appropriate liaison with the physician community. At present, carriers appear to be free to ignore the need for appropriate liaison and responsiveness. This fosters the view among many physicians that the primary role of utilization review is cost control not assuring appropriateness.

Following from this, we would challenge recent policy changes of the Health Care Financing Administration to now prohibit the release of information on the screens used for performing reviews of services. We believe that this inappropriately eliminates useful discussion of the clinical basis for such screens and undercuts physician confidence in the correctness of the review process. We are not convinced such screens are purely a management tool unrelated to clinical appropriateness. We hope that you will examine this isssue.

Much remains to be done in Georgia on resolving ongoing problems with the definition of comprehensive services, compensating those physicians whose services were inappropriately downcoded, and in resolving similar problems with regard to consultant and concurrent care. This includes resolving the problem of documentation, ensuring that such requests are not inappropriately burdensome, and that patient confidentiality is not abused. We urge that a process be agreed to by all parties for resolving these issues promptly.

In conjunction with this, we urge development of a mechanism for temporarily resolving the ambiguities posed by the present coding system while we await recomendations for reform.

We would ask your help in assessing the appropriateness of MAAC levels for selected services, and if problems are found, we would request that necessary technical adjustments be required from HCFA.

As indicated earlier in this statement, we recommend serious analysis of the appropriatenes of contract awards to for-profit enterprises and an examination of what may be inherent conflicts of interest for such enterprises.

In light of the numerous short-term problems remaining from the perspective of the internal medicine community, and what we anticipate will be the view of HCFA, Aetna, and HealthCare COMPARE, that there are no difficulties, we would take the unprecedented step of suggesting that you convene, under the auspices of the Subcommittee, a working group of all interested parties to attempt to reach solution on these issues. Obviously, the College would ask to be a part of any such workgroup. In addition to solving immediate problems, we believe that such a workgroup would help to lay the groundwork for applying the lessons of the Georgia experience to the Medicare program on a national basis.

CONCLUSION:

In closing, we would emphasize that internists in the state of Georgia have reached an unprecedented level of frustration with the Health Care Financing Administration, Aetna, and HealthCare COMPARE.

Events of the past year indicate much lip service, but little practical willingness to resolve problems. In fact, we expect that you will hear from HCFA and-others that there is no longer a problem in Georgia. This is not true, and is indicative of their ongoing disregard for the views of highly responsible members of the physician community. Any attempt to paint the circumstances in Georgia as nothing more than the predictable whining of a group of greedy physicians is a tremendous disservice to those internists who have spent years caring for elderly patients, including the most clinically complex and seriously ill of these patients. It is a particular disservice to the American College of Physicians given our longstanding national reputation as leaders in setting clinical guidelines and standards for internal medicine and in view of our consistent track record as advocates for good patient care and for systems reform.

This apparent lack of accountability and lack of recourse with regard to the actions and statements of HCFA and groups such as Aetna, and HealthCare COMPARE has profound effects both in Georgia and elsewhere. It is contributing to a rising level of cynicism among practitioners about government and federal operations that may seriously undercut the abilility of progressive and responsible organizations to be strong advocates for reform. On a highly practical level, it is leading good internists to abandon practice for early retirement or to close their practices to new Medicare patients.

The increasing administrative burdens of practicing medicine in 1990 are also contributing to the difficulty that we are experiencing

in Georgia and elsewhere in recruiting new physicians into primary care medicine. The consequences of these practical effects are particularly troubling in view of statistics indicating that 29% of physicians are fifty-five years of age and older. We may face a time when despite our national policy goals there are not sufficient primary care practitioners to care for the Medicare population.

Again, we would like to express our deep appreciation to the members and staff of this Subcommittee for your past efforts at reform and for your assistance in unraveling and, we would hope, solving the problems experienced during the past fourteen months by physicians in Georgia. We are prepared to work with you in resolving the immediate difficulties at hand and in setting a course towards fundamental reform over the longer-term.

Thank you. I would be pleased to attempt to answer any questions that you might have.

Mr. WAXMAN. Thank you, Dr. Copeland.

Dr. Bailey, I would like to ask you first about what knowledge the physicians have of the medical review criteria being used and what involvement or consultation, if any, the physician community has had in their development and application.

Mr. BAILEY. Mr. Chairman, antecedent to the implementation of the guidelines that were developed after the arrival of Aetna and HealthCare COMPARE, we had no knowledge of any new or changed guidelines that would be employed from the experience that had been had with Prudential, the former carrier.

Late in the program, in 1989, we finally became involved when we realized that there was a tremendous backlog of unprocessed claims. In February and March, I don't remember the exact number, but it was somewhere in the neighborhood of 800,000 unprocessed claims and physicians in Georgia suddenly were cognizant of the fact that they were not being paid for the services rendered. It was at that time that we subsequently went to Washington and Congressman Rowland was kind enough to call a meeting of the Georgia delegation and at my suggestion as representative of Dr. Joe Nettles and the Medical Association of Georgia, we established a committee which has had ongoing monthly meetings which has led to an increased dissemination of information. But that dissemination of information has still not been adequate, nor has it adequately involved us in the process of decisionmaking.

Mr. WAXMAN. When a carrier or medical review agency first reviews a claim and they conclude it should not be paid, is the physician notified and given an opportunity to provide additional information to support the claim?

Mr. BAILEY. Subsequently, that is certainly done. The process of the conversion or the understanding of claims processed for appeal, however, is a lengthy and difficulty thing and it has resulted in a tremendous amount of backlog in terms of time and effort. And if I could submit to you how Medicare questions are answered in Georgia, we made up a little sheet that I will be glad to give the secretary, defining the laborious telephone calls and multiplicity of channels that are necessary to arrive at an appeal of a problem that you have. [See p. 93.]

But it is so difficult and so costly to the physician, that ultimately it may be not worth the effort to engage in it.

Mr. WAXMAN. How do you think—and this is one of the key things that we are concerned about—how do you think this affects the patients, how does it affect the kind of care that they are getting?

Mr. BAILEY. I think that this can best be answered by the fact that a telephone conference bank was developed here in Atlanta last year that ran for 2 days and in the process there were 3,000 patients that called in with complaints about the process they were being subjected to. But I would like to also call your attention to another point, Mr. Chairman, if I may, and that relates to the fact that about 85 percent of the claims in Georgia were processed on an assigned basis. This means that the patients are not necessarily subjected to much in the way of difficulty. There are only 15 percent in the nonassigned group. And by virtue of that, many patients, I am sure, if they are in that 85 percent assigned group,

may never have any problems with the process, but they ultimately have a problem when the physician does not get paid and the services that the physician provided then are called into question.

Mr. WAXMAN. Certainly if a physician is not being paid, he is not going to be able to see the patients even on an assigned basis. Dr. Copeland, what has been your experience with the impact on the patients? Are doctors turning some of those patients away?

Mr. COPELAND. Of course they are. For the record, let me—I am in full time private practice. You call me at night, I answer the phone. I am a clinical professor of medicine at two major regional medical universities. What Medicare allows for a limited office visit for me is $19.80, of which they pay $15.84. We may or may not, according to our contract, collect the other 20 percent. For an intermediate—all this stuff in the paper about all these incredible costs—charges, a bunch of doctors getting rich and needing to be all of them treated like common criminals—for an intermediate, what Medicare allows, mind you, in my office is $24.70 of which that costs HCFA $19.76. For a so-called extended, they allow $30.75 and pay $24.60. For a comprehensive, mind you, all the roar you have heard about that, they allow me in practice 22½ years, $59.60 and HCFA sends me a check, if they approve it, which they rarely do without me having to write letters and letters and letters, for $55.68.

For me to have to appeal, and I have about six of my own with me, codes that were submitted as comprehensive and were refused, were downcoded all of them past extended, past intermediate to limited. All of those I eventually have been reimbursed at a higher level after about the third step in this—talking about all the hoops you have to jump through. It is not worth that to write those letters. I cannot afford to be involved in three appeal steps for what HCFA, if they approve, spends $15.84. I will bet you they spend $1,000 with their own appeal system and I would also point out to you that the patient that I talked about getting this letter saying that what I had done was wrong, got that letter 20 days before I appealed the case and was aware that I needed to.

The patients are taking a beating, they do not understand, but even much more important than those numbers—I wanted those numbers in the record just so that at least somebody knows there are still hardworking, fair-charging people who are concerned about patients. You cannot have a whole practice on those kind of numbers.

The most important thing though is what you will see, my prediction, 5 and 10 years from now. You just simply will not see people make careers of primary care. I think the impact on the attractiveness of internal medicine and primary care family practice, the real hands-on, particularly with an aging population, increasingly complicated population to take care of—why did HealthCare COMPARE go after them? They went after them I suspect for the same reason that Aetna went after the chiropractors' little bitty charges, they thought they would not get much of a groundswell. They paid $750,000 to get the chiropractors quiet about charges that they had mishandled on these small claims. I think they came after the primary care doctors, the rural physicians in Georgia, because that is the soft underbelly. I have plenty of people who will

not write a letter, friends that say I am not going to do it. You can see, you cannot afford to write a letter for that.

Even more important than that is the trust that is so important in good medical care. If you do not trust your physician, you do not feel good about him, if there has been such a—in the name of monitoring utilization and review, if you create a system that is so tight that everyone is assumed to be a crook, you are going to lose the crown jewel, and that is that sensitive patient care that is so important to people getting better. And that is what is really going to take a beating. And the other—the patient care issue I think is incredibly relevant, I think it is the most important one. I think the other is the attractiveness of a health care career in taking care of people. People are not going to do a $4,000 procedure and get beat up on like we are doing today.

Mr. WAXMAN. Thank you very much, Doctor.

Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman.

Dr. Bailey, you and Dr. Copeland were very definite in saying that the contract with HealthCare COMPARE should be terminated. I assume then that you think the principal problem with all of this turmoil rests with HealthCare COMPARE. I would like to just explore that a little bit further because we are looking for the reasons that we are having problems, to try to address those reasons.

I would like for you to expand on that some. Why do you think that is a problem? Do you think the system would have been different had this experiment not been attempted in the State of Georgia and that Aetna would have had the responsibility in-house rather than having a group external to determine appropriateness of claims?

Mr. BAILEY. Thank you. Congressman Rowland, I think first of all you have to look at the history of the physicians in Georgia and their relationship to other peer review activities that have been conducted here in the past. They were handled in an equitable and reasonable fashion and we responded in positive way to those review agencies.

As you know, as I mentioned in my testimony, in Georgia, we developed the Georgia Medical Care Foundation for the sole purpose of conducting review activities. The Georgia physician is willing to subject himself and actively wants to participate in review of medical care programs for the reason that this is one way that we improve on those things.

Simultaneously, however, when you look at the issue with HealthCare COMPARE, one of the first things we experienced was the downgrading of services for comprehensive medical evaluation. They allude to the fact that we were performing these services in a greater level of frequency than other parts of the country. We have got a lot of sick folks and aging people in the State of Georgia, have a large indigent population and there are reasons why possibly this was occurring, plus this had been accepted by the previous Prudential Insurance Co. in their internal review as acceptable performance, and we have letters to document this.

I think another problem was the issue of concurrent care that has been alluded to specifically by Dr. Copeland. This is a major problem when you have, as nobody knows better than you, a

person in today's society who is ill, has available to him or her a tremendous expertise that was not present in years past and it takes multiple physicians with multiple expertise to provide that care.

We have had experiences in Georgia, for instance, where we are required to go to nursing homes every month and see patients in those nursing homes. But suddenly the criterion was to go, I believe, four times a year—I do not remember the exact figure that HealthCare COMPARE recommended to Aetna to use in their screens and we would have been in violation, in essence, of State law. They subsequently said they would change that rule, but then it was not changed and they had to go back a second time before we could get this accomplished.

There are other instances where we have had things of this nature occur that lead us to believe that the capacity to work with this group in developing fair and equitable guidelines for the implementation of care does not exist.

I want to tell you the confusion, the stress, the genuine anger that has developed in our State towards the consideration for the continuation of this program is so great that I do not think I can verbally convey to Congressman Waxman and yourself just how vehement this is at this time. We are people very interested in the welfare of our fellow human beings. That is why we are in medicine. And as Dr. Copeland pointed out, in primary care, and particularly in taking care of the aging population which is represented by the capacity of Medicare to help them, we are not—we do not see the potential for continuance of the current situation with HealthCare as feasible and reasonable.

They have two physicians in the State of Georgia, both of whom are trained in obstetrics and gynecology. The remainder of their physician cadre that carry out reviews are located in Chicago I assume, but not in the State of Georgia. Recently they have tried to recruit some reviewers in the State of Georgia to augment the people they have in Savannah, but the backlog of claims, the difficulty in appealing these claims, unknown criteria to be judged by. These are the reasons why we are very upset about it.

Mr. Rowland. Let me ask you this. It seems to me that obviously it should have been in the best interest of HealthCare COMPARE that this work because this was an experiment that we were doing, that was taking place here in our State and if it had worked well, then it would have taken place in other States. So it seems to me that they would want it to work. So my question is what happened, why has it not worked. It seems to me that it is self-defeating for them for it not to work.

Mr. Bailey. There was no communication early on, and obviously there are many reasons why it might not have worked. One of the things that we thought might be a reason, this was a pilot, experimental project. If it was successful here in saving money, possibly it would lead to the expansion of their activities throughout the United States. That may or may not be true, but certainly that is an opinion that many of us have as to the explanation for why we were treated as we were.

Mr. Copeland. I would like to comment a little further on that, agreeing with what has just been said but also pointing out when

HealthCare COMPARE came to Georgia, the thing was pushed around it was going to be physicians reviewing physicians, and that was very welcome and there were physician groups who helped with that. And it made it all the more paradoxical and dumbfounding to try to work with people. I invited—had Allen Corn in LaGrange, down here numerous times. But the thing that became compellingly and exhaustingly evident was that we were being told what we needed to hear and I must say in very convincing terms. He defused a number of very upset folk. But the thing about it was that nothing ever happened. We still have not had a meeting to talk about concurrent care like the citizen I talked about here. There still have not been, to my knowledge, ever convened a meeting and we are 15 months into this.

Nobody knows what the criteria for success in that experiment—I have never heard anybody that seemed to know what the definition of success was. I mean an experiment is a pretty well structured undertaking. What is it to be, is it purely money saved? They have saved a heck of a lot of money. How have they saved it? By intimidating a lot of people, overwhelming them with requirements for documentation, confusing them and I certainly do not want their numbers to somehow recommend this group for transplanting to other States around the country because I do not think they represent anything like what they refer to. I think they represent the undoing of basic patient care on the primary level. I cannot believe that a company like that would have gone after these little bills. The average bill that they have gone after is $65, and created such a tremendous amount of paperwork. I am sure every time they shuffle paper that is another click on their reimbursement bit.

But the criteria are not evident. The fact that it became obvious to us that we could talk to them, talk to them and thought we had things taken care of. Finally they took me off the mailing list. The only thing I get is occasionally if I write one of them directly. I am telling you they are—I can show you evidence of problems with veracity that will just absolutely blow your mind, saying one thing one time and something else another time.

And what I would come back to is the basic question, if in fact there was a work group put together from someone from the Congress, at least maybe we could have some reassurance that what we talk about would amount to something.

Mr. ROWLAND. You know we had a meeting in Washington and we had the people come and I thought this was going to form the nucleus of that type of group because we had—Dr. Bailey was there and we had the head people there. What happened to that?

Mr. BAILEY. We have met regularly, we continue to meet on a monthly basis. There are representatives from HCFA, there are representatives from Aetna, there are representatives from HealthCare COMPARE, there are representatives from the Medical Association of Georgia, from the American College of Physicians, from ASIM, sometimes from the Family Medicine people and we are meeting on a regular, ongoing basis. The issue I think that Dr. Copeland is alluding to is whether or not the ultimate input and change from those meetings will be sufficient to justify the effort that has been placed in those. I feel personally that they have made a significant and valuable contribution to changing things in

the State of Georgia. But what we are also saying to you, Congressman Rowland, is that the change has not been sufficient and that the continuum of the presence of this organization in our State constitutes a nitus of unrest and unsatisfactory performance from the physician and patient standpoint that is basically unacceptable.

I think one thing, in answering your question and also Congressman Waxman, in my written testimony representing the Medical Association, one of our recommendations that I did not verbally express today was launching of a public relations effort between the Medicare carrier and Medicare recipients and the physician community to reestablish mutual patient trust concerning reimbursement decisions. That is how bad I think this situation is.

We still do not have a policy handbook. We have gotten several letters and communications of a nature that are helpful, but we do not have a policy handbook representing what Aetna and HealthCare COMPARE intend to use in the development of decisions about reimbursement for patient care activities in the State of Georgia.

Mr. ROWLAND. Are you saying the rules keep changing, the rules keep changing that you have to go by, so you do not really know what the rules are?

Mr. BAILEY. The rules have changed several times since 1989, the beginning of that year.

Mr. COPELAND. I would like to make one other comment about the problem with credibility. On the second day of—the evening of the second day of November 1989, HealthCare COMPARE convened a meeting of presidents of specialty societies in Georgia here in Atlanta, ostensibly by announcement to talk about consultation. Actually the things were so hot that about 90 percent of it was spent on comprehensive. And it was the last such meeting, I point out, that I am aware of. But during that meeting the specific question was asked of the Chairman of HealthCare COMPARE, Dr. Robert Becker—specific question was asked of him, if he agreed with the definition of comprehensive as being once in the lifetime of the computer memory of a relationship between a patient and a doctor. There is some stuff in here that I would take large issue—in some of your other material here—but he said that was a terrible mistake, that definition. And when asked if he approved of it, he said no. When asked if he would have approved of it if he had been aware of that being an operating definition, he said absolutely not. And then I asked him myself can you identify those charges that have been downcoded or denied that under a new—under a revised definition, which has been referred to, which finally came into being in the 12th month—I said if you admit that is wrong, badly wrong, flawed, and then you make a correction, can you identify those codes that would under the correction be kept. And after some good bit of talking back and forth with his various colleagues, four of them, they said yes, that is in the computer and yes, that would be available to us. And he said 6 weeks.

Thirteen weeks later, I finally got a letter from him, said he had been busy traveling a good bit and said that he was mistaken, that that information was not in the computer. I think when you tell physicians who are working hard, trying to do a good job taking care of difficult patients, you tell them those sorts of things, one

thing one time and something else another—you can go back, if you dig out all your charts and all the explanation of benefits that come in. If you can identify one that you think may meet their current criteria and you resurrect that and send it in, my understanding is that that will be considered as an appeal. I do not think many physicians in this end of the spectrum—this is the short end of medicine, I am telling you, people who are willing to put their hands on patients, trying to take care of them—I do not think you can expect those kind of folks to respect or to have the kind of considerations and that will try to cooperate with them again. I think they have been bitten once, they have been bitten bad, they have been insulted, they have been referred to like they were all thieves and I do not think that—I think it is a cancer, I think it will just get worse and I think even if treated it will still be a cancer.

Mr. WAXMAN. Well I want to thank both of you for your testimony today. We are going to look forward to reviewing the record with you. You have been very helpful in giving us a very sobering picture of what is happening here in Georgia.

Mr. BAILEY. Thank you.

Mr. ROWLAND. Thank both of you very much.

Mr. WAXMAN. I would like to now call forward George Holland, Regional Administrator, Atlanta Regional Office of the Health Care Financing Administration and Emil A. Trefzger, Jr., Regional Inspector General for Audit Services, Office of Inspector General, Region IV for the Department of Health and Human Services who will be accompanied by Linda A. Herzog, Regional Inspector General for Evaluations and Inspection.

We are pleased to have you here for our subcommittee hearing. Your prepared statements will be made part of the record in full and we would like to ask you to limit the oral presentation to no more than 5 minutes.

Mr. Holland, we will start with you, and be sure to pull the microphone over and speak into it so we can get your comments on the record.

STATEMENTS OF GEORGE HOLLAND, REGIONAL ADMINISTRATOR, ATLANTA REGIONAL OFFICE, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND EMIL A. TREFZGER, JR., REGION IV INSPECTOR GENERAL, HHS, ACCOMPANIED BY LINDA A. HERZOG, REGIONAL INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTION

Mr. HOLLAND. Thank you. With me today is Mr. Richard Warren, who is the Director of our Medicare Division in the region.

Mr. Chairman and members of the subcommittee, the Health Care Financing Administration appreciates the opportunity to discuss the performance of Aetna Life and Casualty, the Medicare part B contractor for Georgia, and its medical review subcontractor HealthCare COMPARE. We share a mutual concern for resolving any performance problems exhibited by either Aetna or HealthCare COMPARE as to ensure that Medicare beneficiaries and physicians in Georgia receive the quality and timely service that they deserve.

At this time, I would also like to mention that the new HCFA administrator, Gail Wilensky, has expressed interest in undertaking a fresh look at the overall activities and policies of Medicare contractors in order to develop a more uniform and consistent payment policy. HCFA hopes this will promote improved services to both Medicare beneficiaries and providers.

Medicare paid nearly $33 billion for part B benefits in calendar year 1988; $692 million was paid in Georgia alone. As you know, carriers process claims and make payments for physician and other part B services; review the medical necessity of claims submitted; identify situations and collect payments where Medicare is not the primary payer; and recover overpayments when it is determined that incorrect payment has been made.

As you know, on January 1, 1989, Aetna became the Medicare carrier in Georgia, following Prudential's voluntary withdrawal from all of its Medicare contracts.

We chose Aetna as the Georgia Medicare carrier for several reasons. Besides being a successful carrier in other States, Aetna has multi-State backup capability and had a recent successful experience in handling the New Mexico transition.

HCFA saw the new contractor transition as an opportunity to establish a pilot project to evaluate whether private sector organizations more efficiently and innovatively conduct medical and utilization review, and to determine whether separation of the claims and reimbursement functions of the carrier from the medical review function yielded beneficial results. HCFA also wanted to test the greater use of health professionals in doing medical review. By having Aetna subcontract its medical review function to a private review organization, the value of private sector utilization review techniques could be tested. External medical and utilization reviewers are used to a great extent by private insurers and self-insurance groups.

Aetna selected Illinois-based HealthCare COMPARE, a nationally prominent firm, to perform as the medical review subcontractor. Aetna chose HealthCare COMPARE because it has a great deal of experience in performing a wide range of medical utilization review services and is highly regarded in this function.

I want to emphasize, however, that HCFA's prime contract is with Aetna and we hold them responsible for complying with all terms of their contract with us, including the carrier medical review function.

We do acknowledge that there were transitional problems when Aetna became the carrier in Georgia, particularly with the timeliness and accuracy of claims processed.

In January 1989, Aetna assumed 589,000 pending claims from Prudential. The number of pending claims reached 800,000 by the end of February 1989, partly because of a higher-than-expected ongoing claims workload and more important, Aetna's new inexperienced staff.

We asked Aetna to develop a plan to improve service with regard to appeals and claims payment backlogs, including target dates for reaching distinct improvement milestones. Aetna improved its claims processing timeliness and processed record numbers of claims in March, April and May.

In December, HCFA completed a special evaluation of Aetna's performance since the beginning of fiscal year 1990 and found Aetna has made significant improvements in its operations. In fact, the number of claims pending in November dropped to 274,000, which is well below the normal pending workload of 325,000 for a carrier of this size.

Also in November, Aetna exceeded HCFA standards for nonparticipating physician claims processed in 24 days, all claims processed in 60 days and all claims processed in 90 days. In addition, Aetna's regular telephone services has been rated excellent in all areas since September.

HCFA has reviewed complaints raised by beneficiaries to the Atlanta Journal-Constitution and found in most cases proper action had been taken by Aetna. Nevertheless, in November, Aetna established a special 30-day tollfree hotline for beneficiaries to inquire about payment problems. In addition, Aetna has designated staff and phone numbers to specifically handle congressional inquiries.

We believe that Aetna has essentially resolved its claims processing problems. However, we will continue our monitoring of their performance to assure the quality of the claims processing system.

Prior to conducting medical review for Aetna, HealthCare COMPARE met extensively with Georgia's medical community to advise them of its review criteria and procedures. HealthCare COMPARE implemented a program of medical review consistent with HCFA guidelines using a review staff with exceptional qualifications. It is apparent that the medical community is still dissatisfied with the review procedures.

HealthCare COMPARE focused review in two areas: comprehensive levels of service and concurrent care. HCFA data from 1987 showed inordinately higher rates of comprehensive visits billed in Georgia compared to the national rates. HealthCare COMPARE's review of current billings showed that many physician visits billed as comprehensive were either unnecessary or that a comprehensive level of service had not been provided. There was also a problem with medical necessity documentation for concurrent specialty services in the hospital. As a result, HealthCare COMPARE denied services as medically unnecessary or authorized payment for a lower level of service more frequently than Prudential had in the past.

HealthCare COMPARE continues to consult with Georgia physician organizations about proposed medical review policy changes and alert physicians to these changes through meetings and newsletters.

There have been questions regarding HealthCare COMPARE reviewer incentives to deny payments. Contrary to implications raised by several newspaper reports, HealthCare COMPARE does not gain financially by denying claims. Their subcontract with Aetna provides solely for payment of their administrative costs with no financial incentives based on the results of their activities.

HCFA continues to monitor the performance of Aetna and HealthCare COMPARE. In fact, for several months, we have had a person full time in Savannah monitoring the situation.

Mr. WAXMAN. Mr. Holland, the rest of that statement is going to be in the record.

Mr. HOLLAND. Thank you.

[The prepared statement of Mr. Holland follows:]

STATEMENT OF

GEORGE HOLLAND

REGIONAL ADMINISTRATOR

ATLANTA REGIONAL OFFICE

HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Mr. Chairman and members of the Subcommittee, the Health Care Financing Administration appreciates the opportunity to discuss the performance of Aetna Life and Casualty, the Medicare Part B contractor for Georgia, and its medical review subcontractor HealthCare COMPARE. We share a mutual concern for resolving any performance problems exhibited by either Aetna or HealthCare COMPARE as to ensure that Medicare beneficiaries and physicians in Georgia receive the quality and timely service they deserve.

At this time, I would also like to mention that the new HCFA administrator, Gail Wilensky, Ph.D., has expressed interest in undertaking a fresh look at the overall activities and policies of Medicare's contractors in order to develop more uniform and consistent payment policies. HCFA hopes this will promote improved services to Medicare beneficiaries and providers.

BACKGROUND

The Secretary is authorized to enter into contracts with private organizations, usually from within the private health insurance industry, to act as the government's fiscal agent in the processing of Medicare claims and payment to beneficiaries, physicians, and other suppliers. Medicare contractors are called intermediaries for the Hospital Insurance program, and carriers for the Supplemental Medical Insurance program.

Medicare paid nearly $33 billion for Part B benefits in calendar year 1988; $692 million was paid in Georgia alone. There are 34 Medicare Part B carriers. Carriers process claims and make payments for physician and other Part B services; review the medical necessity and reasonableness of claims submitted; identify situations and collect payments where Medicare is not the primary payer; and recover overpayments when it is determined that an incorrect payment has been made. Additionally, carriers provide information and assistance to beneficiaries and physicians on the administration of the program. For the most part, carriers are reimbursed for their costs in carrying out these duties subject to standards established by HCFA.

As you know, on January 1, 1989, Aetna became the Medicare carrier in Georgia following Prudential's voluntary withdrawal from all its Medicare contracts.

NEW CONTRACTOR SELECTION

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- multi-state back-up capability; and
- recent successful experience in handling the New Mexico transition.

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HCFA saw the new contractor transition as an opportunity to establish a pilot project to evaluate whether private sector organizations more efficiently and innovatively conduct medical and utilization review, and to determine whether separation of the claims and reimbursement functions of the carrier from the medical review function yielded beneficial results. HCFA also wanted to test the greater use of health professionals in doing medical reviews. By having Aetna subcontract its medical review function to a private review organization, the value of private sector utilization review techniques could be tested. External medical and utilization reviewers are used to a great extent by private insurers and self-insurance groups.

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I want to emphasize, however, that HCFA's prime contract is with Aetna and we hold them responsible for complying with all terms of their contract with us, including the carrier medical review function.

PROCESSING CLAIMS

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MEDICAL REVIEW

Prior to conducting medical review for Aetna, HealthCare COMPARE met extensively with Georgia's medical community to advise them of its review criteria and procedures. HealthCare COMPARE implemented a program of medical review consistent with HCFA guidelines using a review staff with exceptional qualifications. It is apparent that the medical community is still dissatisfied with the review policies.

HealthCare COMPARE focused review in two areas: comprehensive levels of service and concurrent care. HCFA data from 1987 showed inordinately higher rates of comprehensive visits billed in Georgia compared to national rates. HealthCare COMPARE's review of current billings showed that many physician visits billed as comprehensive were either unnecessary or that a comprehensive level of service had not been provided. There was also a problem with medical necessity documentation for concurrent specialty services in the hospital. As a result, HealthCare COMPARE denied services as medically unnecessary or authorized payment for a lower level of service more frequently than Prudential had in the past.

On this point I would note that although Prudential passed HCFA's yearly performance evaluation overall, in its last three evaluations as the Georgia carrier, Prudential failed to meet medical review standards. HCFA has been monitoring HealthCare COMPARE's policies to ensure that they meet Medicare requirements for medical review. I am pleased to report our interim evaluation found HealthCare COMPARE review decisions to meet HCFA's standards for accuracy.

HealthCare COMPARE continues to consult with Georgia physician organizations about proposed medical review policy changes and alert physicians to these changes through meetings and

newsletters. We believe HealthCare COMPARE is making a serious effort to involve local physicians in the development of its medical review policies. We believe a positive and cooperative attitude will contribute to greater success as HealthCare COMPARE seeks consensus on review policy.

There have been questions regarding HealthCare COMPARE reviewer incentives to deny payments. Contrary to implications raised by several newspaper reports:

- HealthCare COMPARE does not gain financially by denying claims. Their subcontract with Aetna provides solely for payment of their administrative costs, with no financial incentives based on the results of their activities; and
- While mistakes regrettably have been made, decisions by Aetna and HealthCare COMPARE are not "arbitrary and capricious." Decisions follow Medicare law and policy, while both beneficiaries and physicians have appeal rights.

CURRENT EFFORTS

HCFA continues to monitor the performance of Aetna and HealthCare COMPARE. In fact for several months HCFA has had a person working full time at Aetna's Georgia facility to monitor

performance. HCFA also has met with representatives of various medical associations and members of the Georgia Congressional delegation on numerous occasions. HCFA continues to participate in monthly Advisory Committee meetings established by Aetna in June 1989 to provide a forum for discussion with physician representatives.

In November 1989, HCFA asked the Office of Inspector General, as an independent third party reviewer, to conduct several special reviews of Part B Medicare in Georgia. These included:

- o a review of the policies and practices of HealthCare COMPARE compared to review policies of carriers in other states; and
- o a survey of Georgia beneficiaries' satisfaction with Medicare.

Representatives from the Inspector General's office are here today to report their findings.

Another issue which has received a great deal of discussion is HCFA's policy on substitute coverage, where the billing physician must be the physician who rendered the service. It is evident that there are variances nationwide in the way substitute coverage is billed by physicians and paid for by Medicare. HCFA is evaluating its policy in this area and hopes to have a final decision before May 1, 1990. Therefore, Aetna has been instructed to delay its March 1 enforcement of the current policy until a final decision is reached.

CONCLUSION

I look forward to continued progress in resolving differences and meeting the needs of all parties involved. New ideas and proposals to achieve this end would be greatly appreciated.

Thank you. I will be happy to answer any questions you may have.

Mr. WAXMAN. Mr. Trefzger.

STATEMENT OF EMIL A. TREFZGER, JR.

Mr. TREFZGER. Good afternoon, Mr. Chairman. I am Emil Trefzger, the Department of Health and Human Services Regional Inspector for Audit Services. With me today on my left is Linda Herzog, the Regional Inspector General for Evaluations and Inspections.

We are here today at your request to discuss two OIG studies requested by Secretary Sullivan relating to the Georgia Medicare program. Both studies address the performance of Aetna Life Insurance Co., the Medicare carrier for the State of Georgia. One study deals with the processing of physician claims by Aetna and a subcontractor, HealthCare COMPARE. The second study deals with our Medicare beneficiaries satisfaction survey. The reports on the results of the beneficiaries satisfaction with Medicare services in Georgia was issued last week and I would like to submit it for the record. We plan to complete the review and issue a draft report to HCFA on physician claims processing later this month.

The continued media and congressional interest—as I mentioned, prompted Secretary Sullivan to make his request in November and as a result of his request, we initiated these two studies to determine whether contractor screening was overly harsh or consistent with national policies and whether beneficiaries were feeling any detrimental effects.

I would first like to discuss our study of processing physician claims. The objective of our study on physician claims was to determine whether the carrier was processing claims in accordance with Medicare laws and regulations. We engaged a physician consultant who is an expert on MR/UR claims review, for a second opinion on the processing policies and practices of Aetna and HCC.

The consultant reviewed and made medical determinations on a statistical sample of 214 claims which had been reviewed by HCC because the claims failed their utilization audit during the period October through December 1989. The claims were selected in four strata, of which three were identified as problem areas by the Georgia medical community. The three identified problem areas are initial consultation, comprehensive care and concurrent care services. The fourth strata was comprised of all other physician services.

The Aetna/HCC medical policy statements and protocols for the type of claims in the sample were provided to the consultant. We requested the consultant to evaluate these policies and protocols with HCFA and AMA guidelines and also compare them to those of three other carriers; Kentucky, Tennessee/North Carolina and Florida. The policies and protocols were those in effect during the period from which our sample was selected, October through December 1989.

The consultant concluded that the carrier's policy statements and processing protocols used during October through December were clear and comprehensive. The consultant found no inconsistencies between the policies and protocols of the carrier and HCFA and AMA guidelines.

In addition, the consultant found the policy statements and protocols of Aetna/HCC were generally consistent with those of the three other carriers.

Finally, the payment decisions of the consultant were consistent with those of the carrier.

The consultant had no knowledge of the carrier's decisions prior to or during his review. The consultant was provided with data identical to that used by the carrier and asked to render a decision from the data at hand.

The consultant reviewed 32 claims for initial consultation services. The consultant and the carrier made the same payment decisions on 25 of 78 percent of the claims. The consultant was more strict on 6 or 19 percent and the carrier was more strict on 1 or 3 percent of the claims.

The consultant reviewed 86 claims for concurrent care and the consultant and carrier's decisions were the same on 88 percent, the consultant was more strict on 8 percent and the carrier was more strict on 4 percent.

Similar percentages occurred for comprehensive care and for other services.

To summarize, utilizing the same MR/UR policy statements, processing protocol, claims audit exception reports and other supporting documentation used by the carrier and consistent with Medicare regulations, the consultant arrived at the same payment decisions as the carrier in approximately 84 percent of the claims. In about 12 percent of the claims reviewed, the consultant's payment decision was more strict than the carrier and on the remaining 4 percent, the carrier's payment decision was more strict than that of the consultant.

Now I'd like to summarize the findings of our beneficiaries satisfaction survey.

In December 1989, the Inspector General's office surveyed a randomly selected sample of Georgia beneficiaries for whom part B claims had been submitted in calendar year 1989. Participation in the survey was voluntary and yielded an overall response rate of 83 percent. The results of this survey were compared to the findings of the 1989 OIG national survey of Medicare beneficiaries' satisfaction to determine if there were significant differences. A written report of the Georgia study was issued last week.

The survey of beneficiaries found that overall Georgia beneficiaries hold opinions of Medicare which are similar to opinions of beneficiaries nationwide. Eighty-five percent of Georgia beneficiaries stated they are satisfied with the way Aetna has processed their claims, 88 percent of the beneficiaries nationwide are satisfied with the way Medicare carriers process claims. Seventy-three percent of the Georgia beneficiaries think Aetna pays claims quickly enough, 74 percent of the beneficiaries nationwide think their carriers pay claims quickly enough. In the Georgia survey, some beneficiaries mentioned that the processing time had improved in the last several months.

Eighty-three percent of the Georgia beneficiaries and 85 percent nationwide could get information about the Medicare program when needed.

Neither of the OIG reviews indicated aberrant activities of the Georgia carrier. The consultant physician's medical decisions coincided with those of the carrier. Likewise, beneficiary satisfaction with Medicare services in Georgia was parallel to Medicare beneficiary satisfaction nationwide.

This concludes my testimony. Ms. Herzog and I are now available to answer any questions.

[Testimony resumes on p. 150.]

[The prepared statement of Mr. Trefzger follows:]

TESTIMONY
OF
EMIL A. TREFZGER, JR.
REGIONAL INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL/REGION IV
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD AFTERNOON MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES. I AM EMIL A. TREFZGER, JR., REGIONAL INSPECTOR GENERAL FOR AUDIT SERVICES WITH THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITH ME TODAY IS LINDA HERZOG, REGIONAL INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS.

WE ARE HERE TODAY AT YOUR REQUEST TO DISCUSS THE RESULTS OF TWO OFFICE OF INSPECTOR GENERAL STUDIES DONE AT THE REQUEST OF SECRETARY SULLIVAN ON THE GEORGIA MEDICARE PROGRAM. BOTH STUDIES RELATE TO THE PERFORMANCE OF AETNA LIFE INSURANCE COMPANY, THE MEDICARE CLAIMS PROCESSING CARRIER IN THE STATE OF GEORGIA. THE FIRST STUDY I WILL DISCUSS SUMMARIZES OUR PRELIMINARY FINDINGS WITH REGARD TO AETNA'S PROCESSING OF PHYSICIAN CLAIMS. WE PLAN TO ISSUE A DRAFT REPORT TO HCFA ON THIS REVIEW DURING MARCH 1990. THE SECOND STUDY FOCUSES ON THE SATISFACTION OF SERVICES RECEIVED BY MEDICARE BENEFICIARIES IN THE STATE OF GEORGIA. A REPORT ON BENEFICIARY SATISFACTION WAS ISSUED LAST WEEK. WITH YOUR PERMISSION, I WOULD LIKE THIS WRITTEN STATEMENT AND OUR REPORT ADMITTED INTO THE RECORD.

BACKGROUND

ON JANUARY 1, 1989, THE MEDICARE PART B CARRIER IN GEORGIA CHANGED FROM PRUDENTIAL INSURANCE COMPANY OF AMERICA TO AETNA

LIFE AND CASUALTY. BEGINNING IN NOVEMBER 1989, THIS CHANGE RECEIVED EXTENSIVE MEDIA ATTENTION, PARTICULARLY IN ATLANTA NEWSPAPERS. SEVERAL OF THE ARTICLES SUGGESTED THE CHANGES CAUSED SERIOUS PROBLEMS FOR MEDICARE BENEFICIARIES AND THE PHYSICIANS WHO TREAT THEM.

AS THE MEDICARE PART B CARRIER FOR THE STATE OF GEORGIA, AETNA LIFE INSURANCE COMPANY (AETNA) IS REQUIRED, AMONG OTHER THINGS, TO ESTABLISH METHODS FOR IDENTIFYING UTILIZATION PATTERNS AND INSTITUTE UTILIZATION SAFEGUARDS WHICH INCLUDE METHODS OF ASSURING THAT PAYMENTS MADE FOR PART B SERVICES ARE FOR COVERED SERVICES WHICH ARE MEDICALLY NECESSARY. IF, AFTER APPLICATION OF THE SAFEGUARDS AND APPROPRIATE INVESTIGATION, THE CARRIER CONCLUDES THAT A SERVICE FOR WHICH A CLAIM HAS BEEN MADE, WAS NOT MEDICALLY NECESSARY OR THAT THE CLAIM AS PRESENTED IS IMPROPER IN REFLECTING THE AMOUNT AND CHARACTER OF SERVICES RENDERED, THE CARRIER SHALL ADJUST OR DENY THE CLAIM.

TO MEET THESE REQUIREMENTS, AETNA ENTERED INTO A SUBCONTRACT WITH HEALTHCARE COMPARE CORPORATION (HCC) OF DOWNERS GROVE, ILLINOIS TO PROVIDE THE SPECIFIED MEDICAL REVIEW/UTILIZATION REVIEW (MR/UR) SERVICES. HCC IS A MEDICAL SERVICE CORPORATION SPECIALIZING IN MEDICAL AND UTILIZATION REVIEW SERVICES. THE CONTRACT BETWEEN HCC AND AETNA BEGAN ON JANUARY 1, 1989.

HCC CONDUCTS MR/UR FUNCTIONS THROUGH THE USE OF PREPAYMENT AND POST-PAYMENT REVIEW ACTIONS. PREPAYMENT REVIEW REFERS TO THOSE COMPUTERIZED AND MANUAL PROGRAMS FOR REVIEWING CLAIMS PRIOR TO PAYMENT TO DETERMINE APPROPRIATENESS AND MEDICAL NECESSITY OF SERVICES RENDERED TO ELIGIBLE MEDICARE BENEFICIARIES. POST-PAYMENT REVIEW REFERS TO THOSE PROGRAMS WHICH IDENTIFY AND ANALYZE, AFTER A CLAIM IS PAID, INDIVIDUAL PHYSICIAN OR SUPPLIER PATTERNS OF PRACTICE, AND WHERE APPROPRIATE, INVOLVE THE PERFORMANCE OF MEDICAL REVIEW OF THOSE QUESTIONABLE PATTERNS OF PRACTICE.

FROM THE OUTSET OF OPERATIONS, AETNA/HCC EXPERIENCED PROBLEMS CONCERNING THE TIMELINESS AND ACCURACY WITH WHICH CLAIMS WERE PROCESSED. THE CARRIER AND ITS SUBCONTRACTOR WERE ALSO BESET WITH COMPLAINTS WITH THE MANNER IN WHICH MR/UR POLICIES AND PROCESSING PROTOCOLS WERE APPLIED IN THE ADJUDICATION OF CLAIMS. FURTHER, MANY OF THE MR/UR DECISIONS THAT RESULTED IN REDUCED OR DENIED PAYMENTS FOR SERVICES HAVE BEEN DISPUTED BY SOME OF THE AFFECTED PHYSICIANS WITHIN THE GEORGIA MEDICAL COMMUNITY.

IN NOVEMBER 1989, THE SECRETARY REQUESTED THAT THE HHS INSPECTOR GENERAL (IG) CONDUCT AN INDEPENDENT, THIRD PARTY REVIEW OF PART B MEDICARE IN GEORGIA. SPECIFICALLY HE REQUESTED THAT THE IG UNDERTAKE THE FOLLOWING:

- A REVIEW OF THE POLICIES AND PRACTICES OF HCC, INCLUDING THE POSITION OF THE GEORGIA MEDICAL COMMUNITY ON THESE

ISSUES; A COMPARISON OF HCC'S MEDICAL REVIEW POLICIES WITH THOSE OF CARRIERS IN OTHER STATES, AND THE RELEVANT UTILIZATION AND PRACTICE PATTERNS OF GEORGIA PHYSICIANS WITH THOSE IN OTHER STATES.

- A REVIEW OF AETNA'S TIMELINESS IN PROCESSING CLAIMS; AND

- A VALID SURVEY OF GEORGIA MEDICARE BENEFICIARIES' SATISFACTION WITH MEDICARE, SIMILAR TO THE RECENT NATIONAL SURVEY ON BENEFICIARY SATISFACTION.

THE OIG HAS COMPLETED ONE STUDY WHICH IS DESCRIBED IN A REPORT ENTITLED "BENEFICIARY SATISFACTION WITH GEORGIA'S MEDICARE CARRIER." A SECOND STUDY ON CLAIMS PROCESSING IS NEARING COMPLETION AND A DRAFT REPORT WILL BE PREPARED IN MARCH 1990. THE OIG HAS NOT UNDERTAKEN A STUDY OF ACCURACY AND TIMELINESS NOR HAS THE OIG COMPARED AETNA'S PERFORMANCE TO THAT OF OTHER CARRIERS. THE DECISION ON THE NEED FOR, AND THE SCOPE OF ADDITIONAL STUDIES IS UNDER CONSIDERATION AT THIS TIME.

PHYSICIANS CLAIMS PROCESSING

THE OBJECTIVE OF THE STUDY OF PHYSICIAN CLAIMS PROCESSING WAS TO DETERMINE WHETHER THE CARRIER IS CURRENTLY PROCESSING CLAIMS IN ACCORDANCE WITH MEDICARE LAWS AND REGULATIONS AND HCFA GUIDELINES. MORE SPECIFICALLY, WE REVIEWED THE CLAIMS

PROCESSING POLICIES AND PRACTICES OF AETNA AND HCC; AND COMPARED THE MEDICAL REVIEW POLICIES AND PROTOCOLS OF AETNA AND HCC WITH HCFA AND THE AMA GUIDELINES. WE ALSO COMPARED THEM WITH THOSE OF CARRIERS FROM OTHER STATES.

IN ORDER TO EVALUATE CURRENT ACTIVITIES, WE SELECTED A REPRESENTATIVE STATISTICAL SAMPLE OF 214 PROCESSED CLAIMS WHICH HAD FAILED UTILIZATION SCREENS IN ROUTINE PROCESSING DURING THE PERIOD OCTOBER THROUGH DECEMBER 1989. THE SAMPLE WAS SELECTED IN FOUR STRATA OF WHICH THREE WERE IDENTIFIED AS PROBLEM AREAS BY THE GEORGIA MEDICAL COMMUNITY. THESE AREAS ARE: INITIAL CONSULTATION SERVICES, COMPREHENSIVE CARE SERVICES, AND CONCURRENT CARE SERVICES. THE FOURTH STRATA WAS COMPRISED OF ALL OTHER PHYSICIAN SERVICES. THE SAMPLE WAS COMPRISED OF:

- 32 CLAIMS FOR INITIAL CONSULTATION SERVICES;
- 86 CLAIMS FOR CONCURRENT CARE SERVICES;
- 56 CLAIMS FOR COMPREHENSIVE CARE SERVICES; AND
- 40 CLAIMS COMPRISING ALL OTHER TYPES OF PHYSICIAN SERVICES.

THE CLAIMS WERE SELECTED FROM THE UNIVERSE OF PHYSICIAN CLAIMS REVIEWED BY HCC DURING THE PERIOD OCTOBER THROUGH

DECEMBER 1989. A CONSULTANT PHYSICIAN, WHO IS AN EXPERT ON MEDICAL AND UTILIZATION REVIEWS, WAS ENGAGED TO REVIEW THE SAMPLE OF CLAIMS AND MAKE A DETERMINATION AS TO WHETHER THE PROPER CPT PROCEDURE CODE WAS USED FOR SERVICES RENDERED. THE CONSULTANT IS AFFILIATED WITH THE MEDICARE CARRIER IN THE STATE OF KENTUCKY. THE AUDITORS RELIED ENTIRELY ON THE PHYSICIAN CONSULTANT FOR MEDICAL DETERMINATIONS.

THE CONSULTANT:

- COMPARED THE AETNA/HCC PROTOCOLS AND POLICY STATEMENTS FOR COMPLIANCE WITH HCFA AND AMA GUIDELINES.

- CONDUCTED A MEDICAL REVIEW OF THE SAMPLE OF CLAIMS TO DETERMINE WHETHER THE SPECIFIED SERVICE (MEDICAL PROCEDURE) SHOULD HAVE BEEN PAID-AS-BILLED, REDUCED OR DENIED IN ACCORDANCE WITH THE AETNA/HCC POLICY STATEMENTS AND PROTOCOLS.

- COMPARED THE POLICY STATEMENTS FROM AETNA/HCC PERTAINING TO INITIAL CONSULTATION SERVICES, COMPREHENSIVE CARE SERVICES AND CONCURRENT CARE SERVICES TO THOSE OF THE FLORIDA, NORTH CAROLINA/TENNESSEE, AND KENTUCKY CARRIERS, AND

- COMPARED THE AETNA/HCC AND BLUE CROSS OF KENTUCKY PROTOCOLS FOR THE SAME SERVICES.

THE CONCLUSION IS THAT AETNA/HCC WAS GENERALLY PROCESSING PHYSICIAN CLAIMS IN ACCORDANCE WITH MEDICARE LAWS, REGULATIONS AND HCFA GUIDELINES. THE POLICY STATEMENTS AND PROCESSING PROTOCOLS UPON WHICH PAYMENT DECISIONS WERE BASED WERE FOUND BY THE MEDICAL CONSULTANT TO BE CLEAR AND COMPREHENSIVE. THE CONSULTANT FOUND NO INCONSISTENCIES BETWEEN THE POLICIES AND PROTOCOLS OF THE CARRIER AND HCFA AND THE AMA. IN ADDITION, THE CONSULTANT FOUND THE POLICY STATEMENTS AND PROTOCOLS OF AETNA/HCC TO BE GENERALLY CONSISTENT WITH THOSE OF THREE OTHER CARRIERS. FINALLY, THE PAYMENT DECISIONS OF THE CONSULTANT WERE COMPARED TO THOSE OF THE CARRIER AND WERE FOUND TO BE IN SIGNIFICANT AGREEMENT.

THE PHYSICIAN-CONSULTANT CONCLUDED THAT THE MR/UR POLICY STATEMENTS OF AETNA/HCC WERE: "... CLEAR, REPETITIVE, COMPREHENSIVE, AND WOULD SERVE AS A MODEL OF HOW ONE SHOULD APPROACH PHYSICIANS....THERE WERE NO INCONSISTENCIES WITH CPT-4 (AMA) GUIDELINES OR DEFINITIONS. THERE WERE NO VIOLATIONS OF HCFA POLICY IN THE WRITER'S OPINION."

REGARDING THE PROCESSING PROTOCOLS OF AETNA/HCC, THE CONSULTANT STATED: "WITHOUT EXCEPTION, THEY ARE CLEAR,

CONCISE, TO THE POINT AND DO NOT VARY FROM CPT-4 DEFINITIONS OR HCFA GUIDELINES AND DIRECTIVES."

IN THE COMPARISON OF AETNA/HCC PROTOCOLS TO THOSE OF BLUE CROSS OF KENTUCKY, THE CONSULTANT FOUND NO INCONSISTENCIES.

THE CONSULTANT'S REVIEW OF THE SAMPLED CLAIMS WAS SUBSTANTIALLY IN AGREEMENT WITH AETNA/HCC. THE CONSULTANT HAD NO KNOWLEDGE OF THE CARRIER'S DECISIONS PRIOR TO, OR DURING HIS REVIEW. THE CONSULTANT WAS PROVIDED WITH DATA IDENTICAL TO THAT USED BY THE CARRIER AND ASKED TO RENDER A DECISION FROM THE DATA AT HAND.

THE CONSULTANT REVIEWED 32 CLAIMS FOR INITIAL CONSULTATION SERVICES. THE CONSULTANT AND THE CARRIER MADE THE SAME PAYMENT DECISIONS ON 25 (78%) CLAIMS; THE CONSULTANT WAS MORE STRICT ON 6 (19%) CLAIMS; AND THE CARRIER WAS MORE STRICT ON 1(3%) CLAIM.

THE CONSULTANT REVIEWED 86 CLAIMS FOR CONCURRENT CARE SERVICES. THE CONSULTANT AND THE CARRIER MADE THE SAME PAYMENT DECISIONS ON 76 (88%) CLAIMS; THE CONSULTANT WAS MORE STRICT ON 7 (8%) CLAIMS; AND THE CARRIER WAS MORE STRICT ON 3 (4%) CLAIMS.

THE CONSULTANT REVIEWED 56 CLAIMS FOR COMPREHENSIVE CARE SERVICES. THE CONSULTANT AND THE CARRIER MADE THE SAME

PAYMENT DECISIONS ON 43 (77%) CLAIMS; THE CONSULTANT WAS MORE STRICT ON 10 (18%) CLAIMS; AND THE CARRIER WAS MORE STRICT ON 3 (5%) CLAIMS.

THE CONSULTANT REVIEWED 40 CLAIMS FOR OTHER SERVICES. THE CONSULTANT AND THE CARRIER MADE THE SAME PAYMENT DECISIONS ON 35 (88%) CLAIMS; THE CONSULTANT WAS MORE STRICT ON 3 (7%) CLAIMS; AND THE CARRIER WAS MORE STRICT ON 2 (5%) CLAIMS.

TO SUMMARIZE, UTILIZING THE SAME MR/UR POLICY STATEMENTS, PROCESSING PROTOCOLS, CLAIMS, AUDIT EXCEPTION REPORTS, AND OTHER SUPPORTING DOCUMENTATION USED BY THE CARRIER, THE CONSULTANT ARRIVED AT THE SAME PAYMENT DECISIONS ON APPROXIMATELY 84% OF THE CLAIMS. IN ABOUT 12% OF THE CLAIMS REVIEWED, THE CONSULTANT'S PAYMENT DECISION WAS MORE STRICT THAN THAT OF THE CARRIER. ON THE REMAINING 4%, THE CARRIER'S PAYMENT DECISION WAS MORE STRICT THAN THAT OF THE CONSULTANT.

THE CONSULTANT ACKNOWLEDGED IN HIS REPORT THAT THERE SHOULD BE EXPECTED TO BE SOME VARIATIONS IN HIS DECISIONS AND THOSE OF THE CARRIER. HE THOUGHT A 10-15 PERCENT DIFFERENCE WOULD BE ACCEPTABLE REGARDING HIS JUDGEMENT VERSUS ANY OTHER CLAIMS EXAMINER.

SURVEY OF BENEFICIARY SATISFACTION

ARTICLES IN THE GEORGIA PRESS HAVE SUGGESTED THAT THE CHANGES HCFA MADE TO THE PART B PROGRAM IN GEORGIA HAVE CAUSED PROBLEMS FOR BENEFICIARIES. TO DETERMINE THE EXTENT OF ANY PROBLEMS, THE SECRETARY ALSO ASKED THE INSPECTOR GENERAL TO ASSESS BENEFICIARY SATISFACTION WITH AETNA'S SERVICES OVER THE FIRST YEAR OF ITS OPERATION IN GEORGIA.

IN DECEMBER 1989, THE INSPECTOR GENERAL'S OFFICE OF EVALUATION AND INSPECTIONS MAILED A QUESTIONNAIRE TO RANDOMLY SELECTED GEORGIA BENEFICIARIES WHO HAD MEDICARE PART B CLAIMS FILED WITH AETNA IN 1989. THEIR PARTICIPATION IN THE SURVEY WAS VOLUNTARY. RETURNED QUESTIONNAIRES YIELDED AN OVERALL RESPONSE RATE OF 83 PERCENT.

SEVERAL QUESTIONS INCLUDED IN THE SURVEY HAD PREVIOUSLY BEEN USED IN A NATIONAL INSPECTOR GENERAL INSPECTION, "SURVEY OF MEDICARE BENEFICIARY SATISFACTION" (OAI-04-89-89040), CONDUCTED IN JUNE 1989. NATIONAL AND GEORGIA SURVEY RESULTS WERE COMPARED FOR THOSE QUESTIONS TO DETERMINE IF THERE WERE SIGNIFICANT DIFFERENCES. IN SOME INSTANCES, THERE WERE SLIGHT DIFFERENCES IN THE WORDING OF THE QUESTIONS, AND SOME QUESTIONS FROM THE NATIONAL SURVEY WERE ASKED ONLY OF BENEFICIARIES WHO FILE THEIR OWN CLAIMS. OTHER QUESTIONS IN THE GEORGIA SURVEY WERE UNIQUE TO THAT SURVEY AND WERE USED TO ADDRESS THE PARTICULAR SITUATION IN GEORGIA.

A WRITTEN REPORT OF THE GEORGIA STUDY WAS ISSUED LAST WEEK AND WILL BE SENT TO THE GEORGIA CONGRESSIONAL DELEGATION LATER THIS MONTH.

THE SURVEY OF BENEFICIARIES FOUND THAT, OVERALL, GEORGIA BENEFICIARIES HOLD OPINIONS OF MEDICARE WHICH ARE SIMILAR TO THE OPINIONS OF BENEFICIARIES NATIONWIDE.

BENEFICIARIES IN GEORGIA AND NATIONWIDE ARE SATISFIED, IN GENERAL, WITH CLAIMS PROCESSING.

EIGHTY-FIVE PERCENT OF GEORGIA BENEFICIARIES STATED THEY ARE SATISFIED WITH THE WAY AETNA HAS PROCESSED THE CLAIMS THEY OR THEIR DOCTORS SUBMITTED IN 1989. EIGHTY-EIGHT PERCENT OF THE BENEFICIARIES NATIONWIDE WHO SUBMIT THEIR OWN CLAIMS ARE SATISFIED WITH THE WAY MEDICARE CARRIERS PROCESSED THEIR CLAIMS. (IN THE NATIONAL SURVEY, BENEFICIARIES WERE NOT ASKED ABOUT CLAIMS THEIR DOCTORS SUBMITTED FOR THEM.)
THE SURVEY OF GEORGIA BENEFICIARIES COULD NOT DETERMINE IF THE RECENT NEWSPAPER ARTICLES ABOUT AETNA HAD INFLUENCED THEIR SATISFACTION WITH AETNA'S SERVICES; HOWEVER, 39 PERCENT OF THEM SAID THEY HAD SEEN THE ARTICLES. SEVENTY-TWO PERCENT OF THOSE SEEING THE ARTICLES INDICATED THEY WERE SATISFIED WITH CLAIMS PROCESSING, COMPARED TO 92 PERCENT SATISFIED OF THOSE WHO HAD NOT SEEN THE ARTICLES.

SEVENTY-THREE PERCENT OF GEORGIA BENEFICIARIES THINK AETNA PAYS CLAIMS QUICKLY ENOUGH. SEVENTY-FOUR PERCENT OF THE BENEFICIARIES NATIONWIDE THINK THE CARRIERS PAY CLAIMS QUICKLY ENOUGH. IN THE GEORGIA SURVEY, SEVERAL BENEFICIARIES MENTIONED THAT THE PROCESSING TIME HAD IMPROVED IN THE LAST SEVERAL MONTHS.

BENEFICIARIES IN GEORGIA AND NATIONWIDE CAN GET INFORMATION ABOUT MEDICARE WHEN NEEDED.

EIGHTY-THREE PERCENT OF GEORGIA BENEFICIARIES AND 85 PERCENT NATIONWIDE STATED THEY CAN GET INFORMATION ABOUT THE MEDICARE PROGRAM WHEN NEEDED. THREE-FOURTHS IN BOTH SURVEYS SAID THEY THINK THE PROGRAM IS UNDERSTANDABLE.

AROUND 30 PERCENT OF THE BENEFICIARIES IN BOTH SURVEYS INDICATED THEY HAD CALLED THEIR CARRIERS TO ASK ABOUT A SPECIFIC CLAIM. OF THE GEORGIA RESPONDENTS WHO HAD CALLED, 71 PERCENT SAID THEY WERE SATISFIED WITH THE SERVICE THEY HAD RECEIVED FROM AETNA. IN THE NATIONAL SURVEY, 80 PERCENT SAID THEY HAD BEEN SATISFIED WHEN CALLING THEIR CARRIERS.

DURING THE PERIOD COVERED BY THE SURVEY (1989), AETNA ACKNOWLEDGED SEVERAL START-UP PROBLEMS, AMONG THEM THE OPERATION OF THE TOLL-FREE PHONE SERVICE. THE PROBLEM WAS EXACERBATED WHEN THE NEWSPAPERS PUBLICIZED THE NUMBER IN

THEIR SERIES OF ARTICLES. IN ORDER TO ACCOMMODATE THE INCREASE IN CALLS WHICH THE ARTICLES GENERATED, AETNA TEMPORARILY INSTALLED A SECOND TOLL-FREE NUMBER.

SATISFACTION WITH THE APPEALS PROCESS COULD NOT BE DETERMINED.

OVER THREE-FOURTHS OF THE BENEFICIARIES IN BOTH SURVEYS INDICATED THEY KNOW THEY CAN APPEAL DECISIONS MADE ON THEIR CLAIMS. SINCE THE NEWSPAPER ARTICLES INDICATED GEORGIA BENEFICIARIES WERE EXPERIENCING PROBLEMS WITH APPEALS, THE GEORGIA SURVEY ASKED QUESTIONS ABOUT SATISFACTION WITH THE PROCESS. HOWEVER, ONLY 34 BENEFICIARIES INDICATED THEY APPEALED AETNA'S DECISIONS, AND, OF THEM, ONLY 25 ANSWERED THE QUESTIONS ABOUT THEIR EXPERIENCES. THIS NUMBER RESPONDING WAS TOO FEW TO PERMIT ANY KIND OF STATISTICAL ANALYSIS.

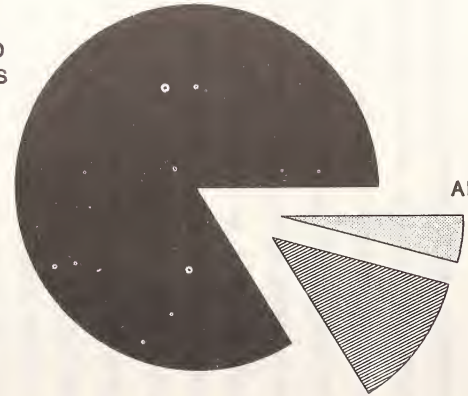
NEITHER OF THE OIG REVIEWS INDICATED ABERRANT ACTIVITIES AT THE GEORGIA CARRIER. THE CONSULTANT PHYSICIAN'S MEDICAL DECISIONS COINCIDED WITH THOSE OF THE CARRIER. LIKEWISE, BENEFICIARY SATISFACTION WITH MEDICARE SERVICES IN GEORGIA WAS PARALLEL TO MEDICARE BENEFICIARY SATISFACTION NATIONALLY. THIS CONCLUDES OUR STATEMENT.

AETNA - GEORGIA

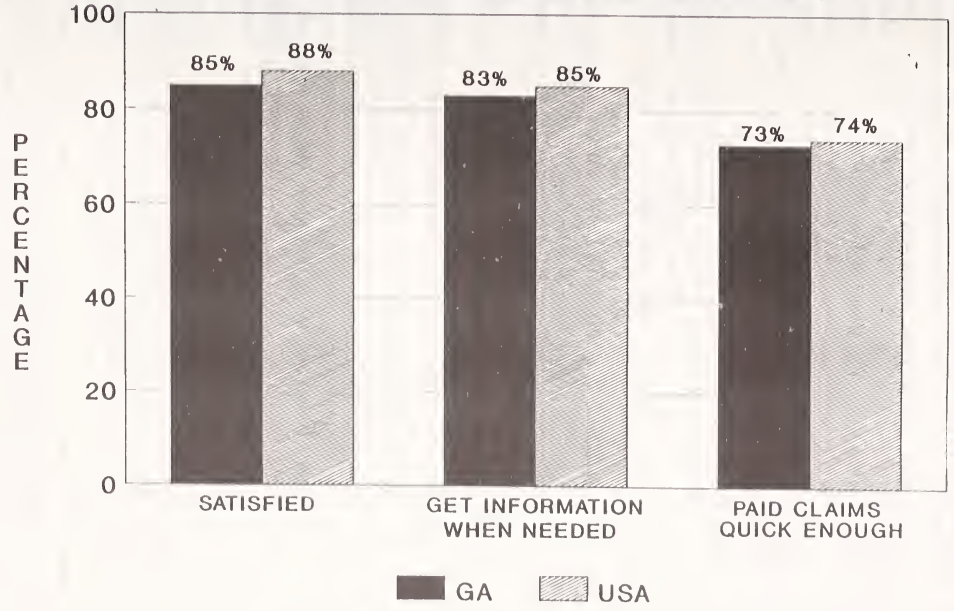
COMPARISON OF PAYMENT DECISIONS

AETNA VS. CONSULTANT

OCTOBER THRU DECEMBER 1989



BENEFICIARY SATISFACTION WITH GEORGIA'S MEDICARE CARRIER



Mr. WAXMAN. Thank you very much for your testimony.

Mr. Holland, can you tell us briefly how Aetna was selected to be the carrier when Prudential announced its resignation?

Mr. HOLLAND. When Prudential resigned from the program, we invited bids and we received bids, I believe, from four carriers across the country, and Aetna was selected from that group.

Mr. WAXMAN. And what was HCFA's role in the process, what organizations were considered and was the Georgia PRO a logical candidate for this task?

Mr. HOLLAND. The other carriers that were considered were Travelers, I believe Equicor, and an organization in Wisconsin. The process was to look at and review each contractor and then make a decision based on history and capability. When we did that, we selected Aetna.

As far as the PRO, I do not believe there is any organization in any State in the country where a PRO reviews for carriers, that I am aware of. They do the inpatient hospital review, but we have never had them do carrier review that I know of.

Mr. WAXMAN. What was HCFA's role in the selection of HealthCare COMPARE?

Mr. HOLLAND. We did not select HealthCare COMPARE, but we told Aetna, as part of the pilot, to go out and hire an outside professional review organization, not an insurance company, a professional review organization, and they selected HealthCare COMPARE out of Downer Grove.

Mr. WAXMAN. Because this was a pilot project, I understand Aetna and HealthCare COMPARE were given discretion or latitude not typical of most contractors. Would you explain what flexibility they had and what rules were relaxed?

Mr. HOLLAND. We usually have mandatory screens, prepayment and postpayment. In the case of HealthCare COMPARE, we allowed them the flexibility, still within our policy and our guidelines—they could not violate that—to set the screens up for the post- and prepayment review within a structure where they would still meet CPT codes, but giving them the additional flexibility.

Mr. WAXMAN. In what ways is the current claims review different from that previously conducted by Prudential? That is, are the areas or types of procedures that are the main focus of review, significantly different now than before?

Mr. HOLLAND. Not really. I cannot really answer that because we are doing an evaluation that will be completed by the end of this month and we will have a fix on it then. But I think we are pretty much in the same areas, but we are getting a stricter review, of course, because we have more personnel on site. I think that is one of the problems that the doctors are having.

Mr. WAXMAN. You indicated that the backlog of pending claims is now down to an acceptable figure. What about the accuracy rate, is it now acceptable?

Mr. HOLLAND. The accuracy rate is not acceptable, but it is a far improvement from 4 or 5 months ago. They should be at about 2.5 percent and I believe they are at about 4.1. So we are still concerned about the accuracy and we are still working on that.

Mr. WAXMAN. What about the reconsideration and appeals process. Is it meeting acceptable criteria for timeliness and accuracy?

Mr. HOLLAND. The reviews are where they should be along with correspondence and telephone service.

Mr. WAXMAN. I understand that the new administrator has appointed a task force to review carrier operations nationally. Can you tell us anything about the composition agenda or time frame for that task force?

Mr. HOLLAND. No, sir, I am sorry, I cannot. I know that she has appointed a task force, but I am not familiar with the details.

[The following information was submitted:]

An internal working group has been formed under the direction of the Deputy Administrator to explore ways to improve the uniformity, efficiency, and performance of the carriers and fiscal intermediaries and to review alternatives to current contractor arrangements. The results of this initiative could make a major improvement in the Medicare program and will serve the best interests of both beneficiaries and providers.

Uniformity.—The Medicare program must be more understandable and predictable for beneficiaries and providers. Geographic variations in such matters as coverage, payment policy, and medical review criteria should be substantially reduced. This initiative will seek to reduce inconsistencies in these and other areas. Clear, consistent information to program beneficiaries as well as to hospitals, physicians, and other providers and suppliers of Medicare services is another significant part of the initiative.

Efficiency.—The Medicare program must be administered as efficiently as possible. Currently, HCFA has 84 contracts with carriers and fiscal intermediaries at an annual cost of approximately $1.5 billion. But the current structure may be inefficient, and may conflict with the goal of uniformity. This initiative will address the issue of contractor consolidation as well as other reform strategies such as standards systems and specialization by provider type (such as the regional home health intermediaries) or function (such as separate contractors for medical review and/or data and/or claims processing).

Performance.—The Medicare program must be a reliable partner in the review and payment of claims. To that end, Medicare contractors must pay claims promptly and accurately and must help foster good beneficiary and provider relations. Contractors must also meet our goals of uniformity and efficiency. This initiative seeks to improve the contractors' performance in these and other areas, and to determine whether HCFA's current approach to performance standards should be changed.

Current activities.—We are currently meeting with beneficiary, physician, provider, and insurance industry representatives and groups to discuss their concerns and identify issues for further consideration. We expect that these meetings will continue through the summer.

Mr. WAXMAN. You mentioned there are no financial incentives in its contract for HealthCare COMPARE to deny or reduce claims. However, I wonder whether it might not have an incentive to do so in order to influence HCFA in obtaining additional contracts in other carrier areas. What do you think about that?

Mr. HOLLAND. I imagine they are a profit organization and like any other profit organization they would like to show a good record in Georgia. At the same time, in addition to the doctor consultant that the IG's office had down there, we have sent nurse teams in there three and four times and we have not found any evidence of them exceeding our guidelines or mandates.

Mr. WAXMAN. Your testimony indicated that HCFA has under review at this time its policy on substitute coverage. Can you tell us what alternatives are under active consideration?

Mr. HOLLAND. They are taking a hard look at the inpatient weekend coverage. We expect a decision on that one by May 1.

Mr. WAXMAN. What is HCFA's policy on the release of medical review criteria? Are the carriers instructed to make these available or keep them secret?

Mr. HOLLAND. On the screens? HCFA takes the position that we keep those within house and they are not releasable; that is, the parameters on the screens.

Mr. WAXMAN. Do you make a distinction between criteria being used to select which claims will be reviewed and criteria used to determine whether the claim should be paid?

Mr. HOLLAND. Would you repeat that question?

Mr. WAXMAN. Do you make a distinction between criteria being used to select which claims will be reviewed and criteria used to determine whether the claim should be paid?

Mr. HOLLAND. There is a distinction between the two.

Mr. WAXMAN. Generally speaking, is the physician community involved in the development of medical review criteria, and how do the carriers go about developing criteria?

Mr. HOLLAND. There has been a lot of work on that. In fact, we did have a lot of physician contact earlier in the program. In fact, even before they started, they had 15 visits with various groups of physicians before January 1. I believe there were 55 different visits after that. But I believe a lot of those visits did not get down to the basic program and the changes that were going to take place. When they did take place, the physicians were not aware of the magnitude that the changes would have on their charges. I think that was one of the problems. But there was a lot of activity in that area.

Now I believe that the process has changed and any time we put out a new procedure, it is given a lot of visibility. It is put out in draft, and the doctors are allowed to respond to it and so are the associations, before it is put in place.

Mr. WAXMAN. The physicians in Georgia have identified several instances in which it was acknowledged that systemic errors had been made and that substantial numbers of claims had been erroneously resolved. They were further advised, however, that while changes would be made prospectively, there would not be any automatic adjustments for the previous erroneously resolved claims. This forces them to pursue individual appeals on each of the prior claims. Is this true?

Mr. HOLLAND. Yes, that is true. We reviewed that with our central office and found it was very difficult to define whether we actually did change the process. The decision was made that we would not go back and would follow the normal process of review and appeal.

Mr. WAXMAN. Is this a general HCFA policy or one unique because of the circumstances involved?

Mr. HOLLAND. With the magnitude of claims in Georgia, unique.

Mr. WAXMAN. Inasmuch as this is a pilot project, I assume that HCFA plans to do an evaluation of it at some point. Can you tell us what criteria you will use to determine whether it has been a success or should be replicated?

Mr. HOLLAND. I am not completely familiar with the evaluation criteria. It is about a 150-page document, but it is extremely thorough. They will of course be comparing HealthCare COMPARE, which is a private utilization organization, to the status quo in North Carolina and I believe Arizona, and to Louisiana and I believe Indiana which will be given flexibility on budget guidelines

and parameters. Then they are going to take the three and make a comparison on a cost/benefit ratio and what happened in those other organizations. But it is a very, very detailed process.

Mr. WAXMAN. We are going to hold the record open and we would like you to submit that to us. [See p. 160.]

Mr. HOLLAND. Yes, we will.

Mr. WAXMAN. What do you think are the lessons to be learned from this experience? In particular, what do you think the affects are on Medicare beneficiaries?

Mr. HOLLAND. We have always heard that the Medicare beneficiaries were being seriously affected by this, but we have had contacts with AARP and obviously we researched and paid careful attention to the letters that we received, and we did not come up with that many complaints.

When the newspaper articles were very heavy on this, we did have a considerable amount of beneficiaries calling in and we were wondering if it was the usual problem with the Medicare program or if, in fact, the articles compounded the situation. We have an extremely high assignment rate in Georgia, close to 80 percent, and as I believe Dr. Bailey indicated earlier, the beneficiaries really would not feel the effects that much.

Mr. WAXMAN. Although they would feel the effect of it if they were denied access to care because physicians did not feel they could take either assignment or the patients at all.

Mr. HOLLAND. But on that, we checked in January and we found that of the 9,500 physicians, only 150 dropped out of the program.

Mr. WAXMAN. That could increase if physician unhappiness goes over a long period of time.

Mr. HOLLAND. We have our doctor letters out now which are encouraging the physicians to participate and we will have a fix on that I believe April 1 and we would be happy to submit that for the record.

Mr. WAXMAN. Great, thank you, we would like to receive that.

[The following information was submitted:]

PHYSICIAN PARTICIPATION RATES IN GEORGIA

The April 1990 participating physician rate in Georgia is 49.4 percent (an actual count of 8,442 physicians). This is a slight increase from the January 1989 participating physician percentage.

Mr. WAXMAN. Mr. Trefzger, I want to thank you and Ms. Herzog for agreeing to testify today on the progress of your studies, even though they are not completed. I do have a few questions about them.

You indicated that you are not reviewing the accuracy of the claims processing in Georgia. That would seem to be an important issue. Are you relying on someone else for that review?

Mr. TREFZGER. We relied on this consultant that we have engaged to review the claims for medical necessity or medical point of view; for accuracy of the claims, we will be doing some of that later.

Mr. WAXMAN. Will you be looking at the timeliness and accuracy of the reconsideration and appeals process?

Mr. TREFZGER. That has not been planned at present. We are in the process now of evaluating what our next step ought to be,

taking into account the present status, the GAO review and initially we had planned to take a look at what is happening with other carriers in the region, but maybe—it is not clear that it is appropriate at this time. We also wanted to take a look at the contracting process and it is my understanding that GAO is well along in that.

Mr. WAXMAN. You indicated that you reviewed the policies adopted by Aetna and HealthCare COMPARE to see if they were consistent with those of other Medicare contractors. Could you elaborate on this for us? I understand that Aetna and HealthCare COMPARE were given discretion not generally available to other carriers. Does that complicate the comparison and how did you take it into account?

Mr. TREFZGER. I would like to submit that for the record. I cannot answer that right now.

[The following information was received for the record:]

The medical policy statements of Aetna/HealthCare COMPARE, relative to the selected procedures, were reviewed by the independent physician-consultant to determine whether they were consistent, and in accordance with, guidelines of the Health Care Financing Administration [HCFA] and the American Medical Association [AMA]. The AMA guidelines are embodied in the text of "Physicians' Current Procedural Terminology" [CPT]. The HCFA policy and guidelines are outlined in the "Medicare Carriers Manual". HealthCare COMPARE's [HCC] processing protocols were reviewed by the physician-consultant to determine whether they were consistent with the policy statements.

In regard to the second part of your question, the subcontract between Aetna and HCC included provisions that exempted HCC from following the same HCFA mandated screens and edits required of other carriers. The HCC was allowed to exercise creativity and innovativeness in developing its own screens and edits. The result of this seemingly discretionary authority was that the degree of review by HCC was more intense and detail-oriented, but still within program parameters. However, since all carriers are governed by the Medicare Carriers Manual, the Aetna/HCC procedures were consistent with those of other carriers. We encountered no complications in the comparison of HCC with other carriers.

Mr. WAXMAN. You indicated your consultant compare the protocols used by HealthCare COMPARE with those of the Kentucky carrier. Could you explain what these protocols are and how they are used?

Mr. TREFZGER. I would have to submit that for the record.

[The following information was received for the record:]

The medical policy statements of the carrier define the specific circumstances under which a procedure should be performed in accordance with accepted standards of medical practice. The protocol review guides were developed from the medical policy statements. The processing review guides detail procedural review steps that each medical examiner must follow when reviewing the necessity of a particular medical procedure that failed one or more claims processing utilization screens/edits. The review guides represent, in effect, a series of decisions that are presented to the examiner to evaluate the claim. The decision to pay as billed, reduce or deny, must be made by the examiner based on the steps followed, and decisions reached, throughout the protocol. The decisions of the examiner are reviewed in HCC's quality assurance program.

Mr. WAXMAN. Your consultant indicated that a 10 to 15 percent variation in claims decisions by different reviewers would be acceptable. That strikes me as very high, suggesting that the process is still quite subjective. It also suggests that an individual physician might be understandably confused if 10 to 15 percent of his claims get different results. Do you think this is the best we can

do? Do you have any suggestions on how these percentages could be reduced?

Mr. TREFZGER. Well this is one of the things that we would like to take a look at, and we are thinking in terms of possibly getting another consultant and try to isolate why our consultant felt that 8 to 10 percent could be a variance, whether it was a personal judgment or whether it was the facts in the case. We are in the process of determining some of that now.

Mr. WAXMAN. Mr. Holland, what do you think about a 10 to 15 percent variation in claims decisions by the reviewer?

Mr. HOLLAND. I was struck by the same thing when I saw those numbers and thought that was high. I know the persons that we have put on site reviewing claims decisions are coming up with 93 and 94 percent accuracy and we are pretty much sticking with that, right around that number. So I was surprised when the acceptable variation was that high, unless he did not have up-to-date policies and procedures.

Mr. TREFZGER. I would like to make one other point. That was his observation prior to his knowledge of what the relationship of his determinations were with that of HCC. As I pointed out, the variations are not that much different.

Mr. WAXMAN. Let me turn to the beneficiary survey and just ask one question. If I understand your testimony, a sample of Georgia beneficiaries with both assigned and unassigned claims were compared with the national sample that included only unassigned claims. I would think that the patients' direct experience would differ, depending on whether the claim was assigned, so might their perspectives and answers. Can you separate the Georgia sample and compare patients with unassigned claims with the corresponding national sample?

Ms. HERZOG. Let me just say that in the Georgia survey, we purposely did not screen our beneficiaries whose doctors did accept assignment. We included those beneficiaries because of the press articles that appeared prior to the survey. Some articles indicated that even beneficiaries whose physicians accepted assignment were affected by the downcoding. Although in those instances, it is the doctor who suffers the reduction in payment, a few of the articles indicated that the downcoding discourages physicians from treating Medicare patients and discourages beneficiaries from seeking medical care because they feel their doctors may not be being adequately paid.

We, in our Georgia survey, are not able to separate the beneficiaries whose doctors to accept assignment and those who do not.

Mr. WAXMAN. Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. Holland, you stated earlier that Aetna was required to subcontract with some external group—external to Aetna, that is, for reviewing of claims, and they subcontracted with HealthCare COMPARE. Are you satisfied at this point with what has taken place?

Mr. HOLLAND. I was not satisfied, as I mentioned earlier, with the communication around real issues that were going to come up. But I believe I'm satisfied now with their performance.

Mr. ROWLAND. What do you think about Dr. Copeland's testimony that there are going to be primary care physicians who are

going to be dropping out of the Medicare program and you said a little bit ago, and this was distressing to me, when I heard you say that only 150 had dropped out of the Medicare program. You do not foresee, as Dr. Copeland does, additional physicians dropping out of the program because of what is taking place right now?

Mr. HOLLAND. We have not seen that in the last 3 months. What we have seen seems to be somewhat normal, 100, 150, 90. We will find that out though the letters which recently went out asking the doctors which ones will go for assignment effective April 1. Then we will have a definite number on that and I will put that in the record. That would be the way we will be able to tell.

Mr. ROWLAND. Then you believe Dr. Copeland is not correct in the assessment that he has made?

Mr. HOLLAND. I do not think he is.

Mr. ROWLAND. You mentioned in your survey that you had done that you did not separate those who had read the newspaper articles relative to Medicare reimbursement from those who had not read it—that is not what you said. You did make a difference in those. Would you give me the figures on that, those who had read the newspaper articles compared to those who had not. You did not separate participating from nonparticipating physicians. Okay.

Ms. HERZOG. Let me say that we really have no way of knowing for certain if individuals who read the articles were in fact influenced by their reading of those newspaper articles.

Mr. ROWLAND. That was not a question in your survey, as to whether or not the individuals had read the newspaper articles?

Ms. HERZOG. We did ask them that, but I just want to point out that we do not know if that caused their opinions to be different. We did find that 39 percent of the people that we surveyed had indicated that they read the articles in the newspaper and there was a significant difference in the satisfaction of those who had seen the article and those who had not. Ninety-two percent of those who had not seen the article said they were satisfied with claims processing in Georgia, compared to 72 percent satisfaction among those who had seen the article.

Mr. ROWLAND. Do you think the newspapers influenced that?

Ms. HERZOG. I am not able to say that there was an influence by the articles. I think it is also important to bear in mind that some of those articles appeared on the business pages of the papers and many people do not read the business pages, so there may in fact be a difference in the types of respondents, rather than the influence of the articles themselves.

Mr. ROWLAND. If they did read the business pages, the difference may be even greater than what it was.

We heard earlier from Dr. Bailey that about 85 percent of Georgia physicians treat—accept assignment for Medicare. So beneficiaries may well be insulated from the problems that exist, and you did not make a difference in your survey as to whether or not these patients, these beneficiaries were going to be participating or nonparticipating physicians, accepting assignment or not, is that correct?

Ms. HERZOG. That is correct. In the national survey we did make that distinction. We asked only those patients who submitted their own claims to answer certain questions about the claims process

procedure. In the Georgia survey, since we had learned from the newspaper articles that many beneficiaries were being affected by downcoding and denials, we thought it appropriate to ask all beneficiaries whether or not they were having difficulties with the claims process.

Mr. ROWLAND. Do you think that might skew the results then if the beneficiaries were insulated from the problem?

Ms. HERZOG. I personally would be reluctant to make a judgment on that.

Mr. ROWLAND. Mr. Trefzger, would you make an assessment of that?

Mr. TREFZGER. Pardon.

Mr. ROWLAND. The question is whether or not the physicians accepting assignment or not, would this make a difference in the results that you had.

Mr. TREFZGER. I'm really not in a position to answer that.

Mr. ROWLAND. It seems to me that is really an unanswered question then. We have heard figures that the beneficiaries for the most part that you surveyed were pleased, compared to the national averages.

Ms. HERZOG. They were the same as the national averages.

Mr. ROWLAND. Yes, same as the national average, but we really do not know whether or not what is taking place in Georgia is accurate insofar as beneficiary dissatisfaction is concerned since you are not able to answer this question.

Ms. HERZOG. It is true, we are not able to separate those whose doctors took assignment.

Mr. ROWLAND. I was listening to Mr. Holland talk about the comprehensive care and the fact that so many times it was deemed to be unnecessary and was downcoded because of that reason. I do not want to get into anecdotal situations, but Dr. Copeland mentioned one that was denied because of being unnecessary, a tumor versus a hernia. He worked the patient up and then it was denied as being unnecessary.

Mr. HOLLAND. I would have to see the case on that.

Mr. ROWLAND. I want to ask something about covering physicians, if I can, at this point. I met in December with Dr. Louis Sullivan and the acting Director of HCFA at that time, and we talked about the fact that HCFA would disallow physicians to bill for those services that they did not run, the physician was covering for them, and was told at that time that Georgia was the only State where that was still allowed.

Information on a survey that was done by the Medical Association of Georgia indicates that there may be 43 States where physicians do this, and you have now decided to delay until May 1 the implementation of—would you update me on just exactly where you are with this? As I understand it, you were looking into whether or not you could, by regulation, allow this coverage as it has existed in the past.

Mr. HOLLAND. Dr. Rowland, we sent you a letter on that last week. You probably have not received it. We had a meeting with the medical directors, the doctors, in Baltimore and found similar patterns that the Medical Association of Georgia found in their survey. There was enough there to raise a question with us if, in

fact, the application was universal. Right now, that is going to be discussed with legal counsel and the policy persons and we hope to have an answer on how we are going to handle that before May 1. Consequently, at the last monthly meeting with MAG and the other doctors in Georgia, we postponed any implementation of the concurrent care policy until May 1, until we can further research it.

Mr. ROWLAND. We have heard some differences of opinion here today and of course there has been a lot of hostility that has been generated, you heard one individual say that this had gone so far that it was irreparable, it could not be repaired.

I am very concerned about what is taking place here in the State of Georgia and concerned that it may have ripple effects throughout the entire country. What do you think at this point needs to be done to try to correct the problems that we are hearing about that still exist out there?

Mr. HOLLAND. We do have a vehicle for that. It is thoroughly discussed every month among the doctors, HealthCare COMPARE, Aetna and ourselves. We still seem to have a problem and a great deal of resentment against HealthCare COMPARE and its policies. I do not know what else we could do other than escalate those meetings and make them more active or whether HealthCare COMPARE can have more meetings with the doctors and more dialogue before they put in place more policies. But I thought we were doing that quite efficiently over the last 2 or 3 months.

Mr. ROWLAND. But you heard the testimony that it cannot be repaired now. Does that mean that you are going to continue to try to repair it?

Mr. HOLLAND. We will, unless the evaluation at the end of March shows that there is serious problems with HealthCare COMPARE, but I doubt at this time that we have any intention of canceling the contract which expires in September 1990.

Mr. ROWLAND. In other words, at this point, you intend to continue. If the hostility grows, it will just have to grow.

Mr. HOLLAND. We would hope that that hostility does not continue to grow.

Mr. ROWLAND. Well suppose it does.

Mr. HOLLAND. Then we are going to have a problem and we will have to address that later. We hope that will level off.

Mr. ROWLAND. It seems to me you already have a large problem, there is already a lot of hostility there. As I said earlier, I do not know how many beneficiaries there are, how many providers there are, who have a problem, I do not know whether it is a small number making a lot of noise or not, but I do know that I am hearing a lot and it is a great concern to me that I see that the system is increasingly put in jeopardy, and I think that it is going to very severely impact the delivery of health care in our State here and this could have a ripple effect into the entire country. I urge you to look very closely at it and be very concerned about it, as I am sure you are.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Rowland. Thank you all for your testimony. We will look forward to the further reviews and audits that you will be conducting and submitting to us.

[Testimony resumes on p. 187.]

[The following material was submitted:]

EVALUATION PROTOCOL FOR THE PART B
MEDICAL REVIEW GEORGIA SUBCONTRACT

When Aetna assumed the role of the Medicare carrier in Georgia on January 1, 1989, it brought with it a subcontractor, Health Care Compare (HCC) to conduct medical review/utilization review (MR/UR). Since subcontracted Part B MR/UR is new to the Medicare program, we wish to thoroughly assess the effectiveness of this new arrangement. In order to evaluate the effectiveness of this subcontract, we have entered into a pilot program using control carriers.

Two carriers, called flexibility control carriers, will be given the same flexibility and adequate funding to support it as HCC. These carriers, Blue Shield of Indiana and Blue Shield Arkansas/Louisiana have been given the same scope of work as HCC. Consequently, they need not follow the prescriptive procedures, such as mandatory screens or postpayment percentages, inherent in the current MR/UR function. These carriers have flexibility to design a MR/UR program that best suits their needs as long as Medicare law, regulation and program policies (coverage criteria) are met.

Two additional carriers, called status quo carriers, will serve as a representation of what could have been expected to occur had the project not begun. That is, these carriers will operate under the existing MR/UR procedures. The status quo carriers handle a claims volume similar to Aetna Georgia and the flexibility carriers. They have been chosen to approximate the effects of a transition (Equicor North Carolina) and the corporate policies of Aetna (Aetna Arizona).

This evaluation protocol basically has two major objectives: 1) To evaluate whether providing increased flexibility and funding results in a "better" MR/UR program, and 2) To compare the relative advantages and disadvantages of subcontracting MR/UR. Thus, it is organized into two separate sections.

In order to comply with the requirement for giving a 90-day notice before termination in the event the subcontract is not successful in developing a workable and effective MR/UR program, the initial assessment must be completed prior to July 1, 1989. Given the time lag associated with data accumulation and reporting and analytical time necessary to complete the assessment prior to July 1, we anticipate initial assessment to be extremely limited and would consider, at most, only the first 4 months of operation with a focus on process rather than outcome measures.

The initial 9-month contract period will be evaluated in depth and a report provided by January 15, 1990. Assuming that the subcontract and control carriers' agreements are extended beyond the initial contract period, annual evaluations on a fiscal year basis will be conducted and reports provided by January 15 of each subsequent year.

In order to conduct this evaluation successfully, we require high data integrity and consistency among all the participants (i.e., the four control carriers and Aetna Georgia). This is especially important with

regard to the subcontractor which will experience start-up costs which will not be true for the control carriers. In order to mitigate the effects of these differences to the degree possible, we will request a significant volume of data not generally collected by the program. Regional Office (RO) staff will be requested to carefully review for accuracy and completeness much of the data and to conduct onsite reviews to gather and report information. Reasonable additional funding for all participating carriers for data collection will be available.

Unless otherwise specified, data requested in this protocol will apply to all flexibility and status quo control carriers, as well as Aetna Georgia. Carriers should forward all reports and data to the RO for review. ROs should submit data and reports to the Division of Operations Standards, Office of Program Administration, Bureau of Program Operations, 1-C-6 Meadows East Building, 6325 Security Boulevard, Baltimore, Maryland 21207. RO staff may contact Art Suekoff (FTS 646-5377) with questions concerning MR/UR and Jackie Sheridan (FTS 646-7406) with questions concerning other aspects of the protocol.

I. EVALUATION OF MEDICAL REVIEW FLEXIBILITY

An effective MR/UR program goes beyond denial of medically unnecessary claims. We expect a MR/UR process to have as one of its principal objectives an active educational program targeted at instructing physicians and suppliers in appropriate billing practices and Medicare guidelines as to medical necessity. The evaluation methodology will consider the effects of this aspect of the MR/UR process, such as cost avoidance and beneficiary and provider relations.

In this portion of the protocol we will be gathering information that describes the MR/UR processes in place and data to measure their effectiveness from several aspects. Specifically, we will be assessing effectiveness from data related to accuracy of the MR/UR process, savings achieved and costs avoided, cost to the program, and impact on the Medicare environment.

1. Policy Development Process

To some degree, all carriers have flexibility in the MR process, within the context of RO approval. In this evaluation, two carriers, in addition to HCC, will have additional flexibility in developing new MR processes. As part of the evaluation process, it is important to gather information describing the MR process in use and procedures followed in development and dissemination of medical review policies. This information will not only permit subjective judgments concerning the relative merits of the various MR/UR processes in place among the carriers, but will also assist us in formulating and supporting conclusions based on provisional findings. For example, if data indicate that flexibility creates an

adverse impact on the Medicare environment, it is necessary to ascertain if the negative impact arose because the MR/UR procedures were inappropriate or if they were merely poorly received because they denied claims without prior educational efforts or warning.

In order to compare policy development processes among the participating carriers, it is necessary that each involved carrier be assessed. ROs should schedule an onsite review each year of the project to examine documentation of the process carriers use to develop medical policy. Carriers may wish to keep a file on each process indicating date of decision, notes to record consultations (including carrier's medical director) and reaction, date and method of informing the provider community, date implemented, subsequent reaction, etc., to assist ROs in this review. During this review the RO should determine the following:

- The type and level of professional input obtained during development of the policy (e.g., internal and external consultants);
- Whether the policies developed are consistent with law, regulations, and Medicare Carrier's Manual (MCM) instructions;
- Whether the medical community has been given adequate notice of the policies and related claims documentation requirements, e.g., means of notification and lead time prior to implementation;
- Whether the policy is accurate, clear, up to date and used by the appropriate medical reviewers e.g., quality and timeliness of internal carrier guidelines;
- Whether medical policies are disclosed to requestors.
- How the carriers implemented the goals of physician involvement and fair notice in MR policy setting.
- How did the carriers respond to the physicians' reaction to the new policies. Was community reaction anticipated, and if not, how did they adjust to the unanticipated feedback?
- How does the role description of medical director differ from that in the pre-flexibility setting? Who does the medical director report to and who reports to the medical director?

ROs should review the carriers files to obtain documentation of contact with the community, noting timeliness of solicitation of input and notification of changes. (In accordance with a recent agreement with the American Medical Association, carriers are expected to provide 30 days advance notice to the State medical society of changes in Medicare MR policies.) ROs should interview the carrier's Medical Director to

determine his role in policy development. ROs should also review carrier files for documentation of contact with professional associations during the development and dissemination of new MR/UR policy. In addition, the RO may consider gathering the following information through discussion with carrier officials or other written materials:

- o Specialization within the MR unit.
- o Internal processes, including backups/fail safe procedures, and special audits.
- o External inputs, e.g., provider-supplied supplementary information.
- o Number of cases identified by each screen.

The above information, if available, should be forwarded to central office.

The initial review should be conducted in April 1989 and submitted to central office (CO) by May 31, 1989 in order to be included in the initial evaluation report. In subsequent years, ROs may conduct such reviews in conjunction with routine visits to the carriers. The RO report need not duplicate information already contained in the quarterly MR report, such as description of screens, as this data will be used to supplement this evaluation.

2. Postpayment Policy

We will evaluate the carriers' postpayment processes through the results of a RO onsite review, the quarterly MR report and the annual postpayment review report. ROs should follow the method of evaluation described in section 5261.3 standard 3 of the MCM-Part 2 (Contractor Performance Evaluation Program (CPEP) methodology) in conducting the review. ROs may wish to have carriers prepare a description of their postpayment processes prior to the review to assist them in preparing their report. For flexibility carriers and Aetna Georgia, the review report should specifically cite aspects of the carriers' postpayment policy that deviate from the process as described in section 7510 through 7514 of the MCM. ROs should include a detailed report of its postpayment review in its comprehensive report (see section II. 11) due to CO by October 31 annually.

Using the quarterly and annual MR reports, CO will compare the following data among participating carriers:

- o The number of flagged physicians and providers;
- o Changes in the number of flagged physician and providers over the preceding fiscal year;

- o Overpayments identified and recovered;
- o The percent of postpayment reviews resulting in corrective action;
- o The cost benefit ratio for postpayment

In measuring the effectiveness of the postpayment process, we will consider documentation of a written description of the postpayment process, postpayment cost benefit ratios, and the number and dollar value of overpayments identified and recovered.

3. Effectiveness

A. Accuracy

We propose to measure accuracy of the participating carriers MR program through review of sample cases, analysis of certain QA error subcategories, and analysis of appeal reversal rates.

I. Sample Cases

The RO will evaluate a sample of claims subject to MR that were identified from Category II and III screens. ROs are encouraged to draw 60 sample cases distributed throughout the period. However, if this is incompatible with a carriers system, limited scope sampling will be permitted. The sample claims will be examined to determine that they were correctly paid or denied according to the carrier's medical review policy. This evaluation methodology is identical to that in section 5261.3 standard 1 of the MCM-Part 2 (CPEP methodology). The results of this evaluation, including an explanation of the errors discovered, should be included in the comprehensive report.

Although Aetna Georgia and the flexibility carriers will not be scored on this standard under CPEP, we believe it is an effective measure of accuracy and is appropriate for this evaluation. Of particular interest will be the change in accuracy from the previous year and the relationship of the change to increased flexibility. Therefore, ROs should forward a report of the results of their fiscal year (FY) 1988 CPEP results for this standard to CO as baseline data. The report should specify the number of cases reviewed, the number of errors detected, identify cause and corrective actions initiated.

II. Quality Assurance Coverage Errors

As a further measure of accuracy, CO will analyze participating carriers' error rates in certain coverage subcategories of the Quality Assurance (QA) program. These error subcategories assess the carrier's ability to make coverage determinations that are in concert with Medicare coverage policy and its own coverage guidelines. To the extent that the MR program is not accurate, errors in these subcategories will increase. See section II. 2. B. for additional information concerning this portion of the evaluation.

III. Appeals

As a third measure of the accuracy of the carriers MR determinations, we will evaluate the appeals reversal rate in MR related cases. We recognize that, at times, the opinion of a reviewer or hearing officer will differ from the carrier's guidelines. Further, additional information that was not available at the time of the initial determination is often presented during the appeal. Therefore, reversals can logically be expected. By analyzing the relative changes in appeal rates among the participating carriers and the issues in dispute, however, we believe that we can reasonably evaluate the accuracy of MR determinations and how the carrier responds to indications of necessary change.

In order to conduct this portion of the evaluation, it is necessary to collect data that are not currently available in the carrier setting. ROs will begin by collecting baseline data from the participating carriers and Prudential Georgia and North Carolina. The RO must review a sample of claims subject to review and hearing. The RO may use the sample selected for conducting the FY 1988 CPEP review where appropriate. For hearings, it will be necessary to pull a unique sample of 30 cases for this evaluation. To the extent possible, ROs should attempt to select a sample of cases dispersed throughout the period rather than selecting cases from an isolated point in time.

In reviewing the sample claims, ROs should note first whether the claim involved a MR issue. If so, additional information as to specific issue in controversy, outcome, and availability of new information should be gathered. We have prepared a report form that outlines the data elements necessary for the analysis as exhibit A. The baseline sample review should be conducted prior to December 31, 1988. ROs should submit the necessary report to CO by January 31, 1989.

In order to evaluate the impact of changes on the accuracy of MR decisions, carriers will need to institute an ongoing mechanism for gathering appeals data in the detail necessary for this evaluation. That is, participating carriers must identify and report the number of reviews and hearings that involve a MR issue. For those that do involve MR, the carrier must further identify the issue in controversy, the decision and whether new information which was not available at the time of the initial determination was presented during the appeal.

Carriers may gather this data on a sample basis. We suggest collecting data on closed file cases using selected days in the second, fifth, eighth, and eleventh months of the fiscal year. Category I cases should be sampled as well as categories II and III. Carriers should include only valid requests for hearings (e.g., those meeting $100 in controversy threshold). Minimum sample size per monthly sampling period is 15 reviews and 8 hearings. Exhibit A presents a suggested format for reporting quarterly data.

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B. Savings

In order to assure consistency in MR quarterly report data, ROs should conduct a review of each carrier's system. The review took place prior to January 1, 1989. ROs assessed the systems specifications and software program logic for calculating program savings to assure that savings are determined in accordance with operational policy. We are particularly concerned that reasonable charge reductions not be included as medical necessity savings. For example, reasonable charge reductions arising from recoding lab tests to appropriate panel or from paying the second surgical procedure in multiple surgery cases at a reduced rate should not be included as MR savings.

Based on past review of the MR savings systems, we do not anticipate problems in this area. However if changes are necessary, the RO should assure that they are implemented quickly and should review the system upon completion. ROs reported on their validation reviews to CO by January 31, 1989. ROs should include control carriers as one of the contractors selected for its annual validation review for each year of the project. Results of the validation review should be included in the annual comprehensive report for 1990 and following years.

C. Cost Avoidance

As part of measuring the success of flexibility in administering medical review in the Medicare program, we will attempt to quantify cost avoidance. Measuring cost avoidance is difficult at best, since essentially we are trying to measure the savings associated with improved practice/billing patterns through estimation of what did not happen. The method we are proposing for measuring cost avoidance requires the individual participating carriers to conduct trend analysis. Since there is cost avoidance associated with the current MR/UR programs, the methodology will apply to all participating carriers.

Each carrier prepared baseline data from the fiscal year (FY) 1988 period. The data elements included procedure codes, frequency, and average allowable cost. In order to determine the average allowable charge, carriers should divide the total allowed charges by the total number of services allowed. The baseline data source must be retained in a format that is capable of being sorted and analyzed on a procedure code basis. Prudential Georgia and North Carolina FY 1988 data will be used as the initial base period for Aetna Georgia and Equicor North Carolina, respectively.

We acknowledge that use of this base period may not be truly representative of typical MR/UR effectiveness as Prudential's MR/UR process may have been less than optimal during the FY 1988 period when the carrier was preparing to terminate operations. Nonetheless, it is the only available data that is representative of the practices in the areas. We will use FY 1989 data from Aetna Georgia and Equicor North Carolina to assess FY 1990 and following periods.

In order to conduct cost avoidance analysis, carriers must begin with identifying all providers and procedures where they have attempted altering practices throughout the year. For example, the carrier should list each procedure code identified for educational contact with individual physicians, suppliers and other providers through postpayment practices, as well as all procedures subject to educational practices such as inclusion in newsletters. For those procedure codes that are expected to result in a shift to other codes, the carrier should note the recommended alternative coding.

We see the cost avoidance collection to be a three part process. First, we need to account for those educational contacts intended to result in the elimination of bills submitted for particular procedure codes. If the carrier currently has in place a prepayment screen for such services, it is likely that there would be no benefit payments to be avoided through altering billing practices, as most claims would be denied. However, there may be administrative costs that would be avoided through such educational contacts.

In determining cost avoidance in this scenario, we will calculate the difference between the FY 1988 and FY 1989 frequencies for each individual code and multiply the difference by the carrier's administrative unit cost of claims processing (lines 1 and 2 unit cost from the last FY 1989 Notice of Budget Approval). The result will yield the dollars saved by not having to process the claim. For example, is a carrier receives 2000 claims per year for noncovered cosmetic surgery and its unit cost is $1.50, it would cost the carrier $3000 to process the denials. Educational contact is expected to reduce the occurrence of submitted claims for this service. * Therefore, the difference in frequency of claims submitted times the unit cost per claim equals cost avoidance.

Second, we believe it is necessary to focus on additional codes for which there are prepayment screens in place. Cost avoidance, in this scenario is determined by first calculating the difference between expected frequency (base year volume adjusted frequency) and observed frequency (current period actual frequency). This is multiplied by the average allowable charge for the procedure. (See attached example for cost avoidance computation.)

Third, we will focus on those codes annotated as part of the carrier's educational process for which no prepayment screen currently exists. As stated above, the carrier will provide alternative codes for the level of care described and the provider will be expected to shift billings appropriately. Cost avoidance for this category will be calculated by determining the difference between the cost adjusted differences in the procedures. For example, the carrier will determine the total cost difference for each procedure code identified for change as illustrated in portion two. That is, the difference between expected frequency and observed frequency will be multiplied by the average allowable charge for the procedure and summed. Then the cost shifting total will be determined by multiplying the increase in frequency of expected codes by the average allowable charge and summing. Cost avoidance will equal the difference between reduced codes and increased codes. (See attached example.) Portions 1, 2 and 3 will be summed to determine cost avoidance.

As a final overall indicator of cost shifting, each carrier should determine and report the average charge per claim. We recognize a myriad of factors would influence this figure. However, taken in concert with the other portions of the cost avoidance methodology, we believe the change in the average charge per claim will supplement interpretation of overall cost avoidance.

The cost avoidance report (see exhibit B) will generally be required on a fiscal year basis. The carrier should conduct the analysis as soon as it believes that the frequency count for the fiscal period is essentially complete, but not before November 1 each year. The report must be submitted to the RO for review and validation by December 15. ROs must forward the completed and validated report to CO by December 31 each year.

D. Costs

Since HCC will experience start up costs not present in the control carriers and since two of the carriers have flexibility to significantly alter the relative level of effort in their MR/UR processes, it is necessary to collect cost information in significantly greater detail than currently exists in the financial report of the program. Further it is possible that flexibility carriers may experience costs related to new practices they may choose to pursue. In order to assure comparability among the carriers evaluated, special procedures for validating costs and savings are necessary. The instructions below pertain to all carriers participating in the project.

We have developed a supplemental cost report for this project. This report requires each of the participating carriers to go into greater detail about the costs that appear on the Interim Expenditure Report's (IER) Line 5 entitled "Medical Review and Utilization Review." Wherever possible, this report follows the format of the IER and the definitions of the MCM, Part 1 - Fiscal Administration, Chapter II - Budget Preparation. For instance, the columns "Productive Hours" through "Total" follow the IER exactly.

In order to obtain information regarding productive hours and personal services for HCC, it is necessary that the subcontractor also prepare the supplemental cost report. Aetna Georgia will then prepare a combined report showing HCC's column F figures as subcontract costs and summing HCC and Aetna productive hours and personal services. HCC's individual report should be forwarded as an attachment to the combined report. Aetna Georgia may need to work with the subcontractor initially to assure that the report is completed in accordance with HCFA pub 14-1 instructions.

For the MR/UR Activities (Line 1 - Start up costs through Line 12 - Other Costs), each carrier will need to maintain time studies, timesheets or a log of staff time for each line item in order to assure consistency in allocating the appropriate hours and costs. Hours and costs must be reported only once

If carriers are not sure where to classify certain MR/UR hours or costs, use Line 11 or Line 12 and identify it fully in the remarks section or on a separate page. Use line 13, entitled "From IER Line 5" to record figures as they appear on the line 5 of the IER for the corresponding period. Line 13 and the total cost line above it should be identical. Include on line 14 MR-related costs that may be reported in the IER on lines other than Line 5. These costs should be identified in the remarks section or on a separate page.

The supplemental cost report must be filed for the initial evaluation, as well as annually thereafter. The initial report should cover costs through April 30, 1989 and must be submitted to CO with a copy to the RO by May 31, 1989. Further supplemental cost reports encompassing the entire fiscal period, must be submitted to CO by October 31 annually and may be included in the comprehensive report.

D. 1. Completing the Supplemental Cost Report - See Exhibit C

In the upper left-hand box of the form, enter the carrier's number and name. Enter the cumulative reporting period reflected in the report and the completion date at the top of the page.

Line 1 of Column A covers Start up Costs. Examples of startup costs include, but are not limited to:

- Personnel - costs over and above normal staff turnover, such as recruiting and training
- Physical plant - securing office space and utilities (deposit, hook-up fees, etc.)
- Acquiring Electronic Data Processing (EDP) hardware (only costs associated with acquisition which are not capitalized)
- Initial EDP supply inventory (paper, disks, ribbon, etc.)
- Initial computer software
- Computer programming including systems modifications necessary to permit data transfer between carrier and subcontractor
- Office equipment which is not capitalized, such as office partitions, trash cans, and other items not estimated to have a useful life in excess of three years
- One-time purchases of office supplies, such as reference materials, and initial office supply inventory.

Line 2 covers Policy Development. Examples of policy development costs include, but are not limited to:

- The cost of research, data analysis, planning, etc. conducted for the purpose of developing and implementing changes in MR/UR processes (both pre- and/or post-payment)
- Analysis of the problem or of the scope of work
- Design of the approach to solve the problem, including the basic structure of the program
- Coding of the program, including necessary documentation
- Testing and debugging
- Utilization of specialists for consultation
- Solicited provider input

All costs incurred prior to implementation should be included in this category (line). However, costs associated with dissemination of new policy should not be reported in line 2. Instead, we believe it is more appropriately reported under Professional Relations.

- o Systems modifications necessary to implement changes
- o Development/revision of guidelines
- o Testing of new screens.

Line 3 covers Professional Relations. Include only professional relations costs associated with MR/UR and included in Line 5 of the IER. Examples of professional relations costs include, but are not limited to:

- o Educational contacts arising from MR findings
- o Newsletters
- o Meetings with industry associations
- o Workshops.

Also include travel costs associated with such professional relations activities.

Line 4 covers Category I screens. This is the front-end review and resolution of MR claims, and consists of Category I screens. These reviews must coincide with specific EOMB messages. One example of Category I costs includes a portion of claims processing staff time associated with front-end edits.

Line 5 covers Post-Payment reviews. Examples of Post-Payment costs include, but are not limited to:

- o Development of criteria to identify aberrant practices (category and ratio comparisons, etc.)
- o Data runs of history files
- o Maintaining documentation
- o Screening and reviews
- o Corrective action steps
- o Reporting
- o Overpayment activities
- o Development of the Provider Audit List analysis of data
- o Investigation, if warranted, of establishing Category III screens plus review costs associated with identifying claims.

Line 6 covers Fraud and Abuse. Examples of Fraud and Abuse costs include, but are not limited to:

- o Gathering documentation and preparing referrals to the OIG for sanctions and Civil Monetary Penalty cases
- o Investigations
- o Confrontation interviews
- o Fraud trials
- o Administrative sanctions activities, except those related to Physician Fee Freeze
- o Other case development activities.

Line 7 covers Special Projects. Include the costs of any special projects the carrier implements related to MR activities.

Line 8 covers Routine Pre-Payment Operations. Examples of Routine Operations costs include, but are not limited to:

- o Review and resolution of claims identified as exceptions (category II screens) which possibly represent inappropriate instances of patterns of care related to over/under utilization, medical necessity, upcoding of services and concurrent care.
- o Review/development of claims from physicians flagged for prepayment review
- o Screening of Part A denials against Part B history
- o Flagging of beneficiary history records for the purpose of denying/reducing future Part B claims
- o Review activities involved with the receipt of subsequent claims and requests for additional information/documentation.

Line 9 covers EDP costs. Include all MR related EDP costs. Examples of EDP costs can be found in section 4214 of MCM-Part 1. Assure that EDP allocations are complete, encompassing all portions of MR activities and do not duplicate costs allocated to other line items.

Line 10 covers Overhead costs. Examples of Overhead costs can be found in section 4215 of MCM-Part 1.

Lines 11 and 12 cover Other Costs. Include and separately identify costs for additional data gathering associated with this evaluation. All costs should be identified in detail by the carriers.

Line 13 comes directly from the IER's Line 5.

Line 14 covers costs that may be reported in the IER on lines other than Line 5. Identify in the remarks section, the line item of the IER where these costs are reported.

D. 2. Cost analysis

For purposes of conducting this evaluation, we need to expand MR/UR cost analysis beyond the total savings to total cost ratio that is currently used in calculating cost benefit ratios. Total costs will be net of data gathering costs identified in item 11 of the supplemental cost report. Our cost analysis will include, but not be limited to, the following:

- o Total savings to total cost less start up costs - This will allow us to compare the effectiveness of the MR/UR programs in terms of denials/reductions while controlling for one time costs associated with initiating new processes.

- o Total savings to total cost less start up costs and policy development costs - This will allow us to compare the effectiveness of the MR/UR programs in terms of denials/reductions based on ongoing operating costs.

- o Postpayment savings to the sum of costs for postpayment, fraud and abuse, professional relations - This will allow us to compare the effectiveness in terms of denial/reductions of the postpayment processes.

- o Total savings less postpayment savings to costs for routine operations plus EDP costs - This will allow us to compare the effectiveness in terms of denials/reductions of the prepayment process in relation to ongoing operating costs.

- o Cost avoidance to professional relations costs - This will allow us to compare the effectiveness of the carriers educational efforts.

- o Total savings plus cost avoidance to total costs less start up costs - This will allow us to compare the overall effectiveness of the MR/UR process in relation to its cost while controlling for one-time costs associated with initiating new processes.

- o Total saving plus cost avoidance to total costs less start up and policy development costs - This will allow us to compare the overall effectiveness of the MR/UR programs based on ongoing operating costs.

E. Provider and Beneficiary Reaction

1. Inquiries

As one means of tracking the impact of the new MR processing arrangements on the environment, we need to ascertain the number (percentage) of MR related inquiries. We believe the need to capture this data is an important indicator of how well the new MR processing procedures are being received by the provider and beneficiary communities. The status-quo carriers need to participate in this data collection in order to establish a basis of comparison for the usual number of MR inquiries received under the standard processing techniques.

Since a method to distinguish between MR and all other inquiries is not currently in place at the carriers, we have devised the following instructions. Aetna Georgia and the four control carriers will determine a baseline inquiry status based on FY 1988 CPEP cases and the December 1988 figures. Based on an analysis of total inquiries currently reported, a sample of 60 inquiries annually in each category is needed.

Three categories of inquiries will be evaluated, telephone, written and walk-in. In preparing the sample review, carriers need only tally total number of inquiries reviewed and whether the inquiry included a MR related issue. Where possible, carriers should identify the issue which prompted the MR related inquiry. The results of this baseline sampling review should be reported to CO by January 31, 1989. For the purposes of this initial report, the Aetna Georgia and Equicor North Carolina baseline data will be derived from Prudential data. However, subsequent analyses will rely on Aetna and Equicor figures.

Carriers will need to institute a process for tallying MR related inquiries on a sample basis throughout the project and report this data to CO. We recommend tallying inquiries for selected days during the months of November, February, May and August. Minimum monthly sample sizes are 15 inquiries of each type (if there are that many). Carriers should identify the issue which initiated the MR related inquiries. Inquiries should be considered as MR related if one or more issues discussed is related to MR policy or practices or if it relates to denial or reduction of a claim based on application of MR policies. For this measure it is recommended that the evaluators substitute the rate of inquiries concerning a specific MR issue per 100 claims subject to MR that were identified from a specific screen addressing the same issue. Inquiry rates can then be tracked to indicate provider and beneficiary satisfaction with new processing procedures and in some cases, policy dissemination. Inquiries involving multiple MR related issues should be counted as a single inquiry. However, all issues should be identified. Exhibit D presents a format for collecting this data and should be forwarded to CO within 30 days of the end of the quarter.

2. Reviews and Hearings

In addition to using appeals data to assess the accuracy of the MR program in place, we believe such data are an indicator of provider/beneficiary satisfaction with the MR/UR program. Therefore, we will use workload volume information to measure the impact of the program on the environment. That is, using the information from the baseline sample review data and current period sample data of reviews and hearings related to MR/UR, we can determine the percent change in appeals. We will use the appeals data requested in section I. 3. A. III. for this analysis.

We acknowledge that appeals volume related to MR is not a pure measure of impact of the MR program. There are a myriad of factors that can contribute to an increase in MR related appeals. However, to the extent that a carrier is conducting an accurate MR program and engaging in an active public relations program during policy development, we would expect appeals volume to remain constant or decline. Further, appeals volume changes taken in concert with other indicators of environmental impact, serves to confirm the conclusions that may be drawn from analysis of these data. That is, if all data elements used to assess environmental impact change similarly, it is more likely to be related to change in the MR processes.

3. Provider Survey

ROs should survey medical societies, as well as appropriate relevant professional associations to elicit their opinion regarding the carrier's process for developing and disseminating medical policy. CO will provide guidance in the development of survey questions to assure consistency in the survey results and assist in formulating questions that seek responses to carrier actions rather than physician personal satisfaction/ dissatisfaction with the denial or approval of claims. We intend that the survey be conducted during April 1990 and responses with RO analysis should accompany the RO's report for that year.

We will use the results of the provider survey to assess the carrier s procedure for assuring timely dissemination of policies and changes to those policies and interaction with appropriate medical specialty societies.

F. Administration

ROs should submit a report describing administration of MR/UR in the carrier. The report should include the number and occupational mix of staff (e.g., number of physicians, nurses, supervisors and clerical staff), the type of issues handled by each type of staff, and a general description of the MR/UR process and how it is administered.

This report should be based on findings of an on-site review and can be combined with other necessary on-site review visits. ROs should forward the report on administration for the initial period to CO by May 31, 1989. Subsequent years reports may be included in the comprehensive report required by October 31 each year.

II. EVALUATION OF SUBCONTRACTING

In general, the CPEP process will provide much information in determining the effect of subcontracting MR/UR on the carrier s overall performance. The CPEP standards present a commonly accepted and operationally defined level of performance for all major aspects of a carrier's operations. In the sections that follow, each CPEP functional criterion is identified. We have delineated those standards that are likely to be impacted by changes in the MR process and by use of subcontracting. In this document, we have identified the evaluation steps that will be performed, including data sources and methodology for comparison. Several individual areas will require data that are not currently available.

1. Unit Cost

We anticipate that total costs of the subcontract will be isolated and reported exclusively in the medical review line item of the carrier's financial reports. Therefore, the subcontract should not directly effect the unit cost standards assessed in CPEP. However, since the subcontractor must interface with the carrier's claims processing system and may need to support the appeals and inquiries process to the extent that necessary information may not be directly available to the carrier, subcontracting could potentially impact on the carrier's unit cost for claims processing, reviews, reopenings, hearings and inquiries.

In order to evaluate this possibility, we will analyze the unit cost measures determined in accordance with the CPEP method of evaluation presented in section 5261.1 of the Medicare Carrier's Manual (MCM). We will compare the unit cost figures between the participating carriers and analyze the change in these figures from past periods. Prudential Georgia and North Carolina will be used as the baseline for Aetna Georgia and Equicor North Carolina for the first assessment. Therefore, we acknowledge that percent of change figures will not be conclusive. However, such analysis should provide some indications of any significant impact of subcontracting on unit costs.

ROs should assess the interface between the medical review function and the participating carriers' operations as it relates to claims processing, appeals functions and inquiries and forward a descriptive report to CO in its comprehensive annual report due October 31. The report should include a narrative explaining the carriers process for obtaining necessary information concerning medical review, mechanisms for controlling requests, approximate average time lapse in obtaining information, and any observable factors that could influence cost. If the project is extended beyond the initial period, subsequent reports need only highlight any changes to the procedure that have occurred since the previous report.

We acknowledge that this mechanism represents a fairly subjective measure of the impact of subcontracting on unit costs. However, taken together with cost comparisons, we believe it is a satisfactory means of evaluation. We will also consider any additional information involved parties wish to submit.

2. Claims Processing

A. Timeliness

All control contractors will be responsible for meeting the Claim Processing Timeliness (CPT) requirements applicable each year of the project. We will use CPT data routinely reported to CO. However, for this project it will be important to document the impact of the subcontractor and any of the MR/UR processes on CPT. The direct impact will be shown by the length of time it takes to process claims through MR/UR. This information also must be obtained from the control carriers for baseline comparison purposes.

Within the control system of each carrier's claims processing system a location should be created for claims referred to the MR/UR unit. Distinction between CPT categories, i.e., "clean claims from participating physicians, other clean claims, and other claims processed within 60 and 90 days, should be reported separately. For each CPT category, carriers must report the total volume of claims, the volume of claims referred to the MR/UR department or subcontractor, and the average number of days the claims were controlled to MR. We believe these reports can be easily accommodated in the control systems used by the contractors. Should contractors use MR/UR processes that adversely impact timely claims processing, the status indicators would show problems.

All participating carriers should implement this reporting January 1, 1989 and submit monthly reports to the RO within 30 days of the close of the reporting period. The ROs should forward a copy of the monthly reports to CO upon receipt. Monthly reporting has been chosen to coincide with other workload and CPT reporting required of carriers.

B. Quality

The principal measure of claims processing quality is the QA program. We will be looking closely at QA scores of participating carriers to assess impact of the project on claims processing quality. Specifically, we will be reviewing QA underpayment deductible, overpayment deductible and Explanation of Medicare Benefits error rates. CO will conduct this portion of the evaluation based on the data routinely reported.

In conducting this portion of the evaluation, we will use individual subcategory error rates from Table 5 of the cumulative QA reports. Base period data will be gathered at CO for FY 1988. We will use data from Prudential Georgia and North Carolina as a baseline for Aetna Georgia and Equicor North Carolina. We acknowledge that FY 1988 data from Prudential may not reflect typical practices in the area as the carrier was preparing for termination of its contract. We will, therefore, also use year to year comparison (rolling base periods) if the project is extended beyond the initial 9-month period.

We also acknowledge there are some methodological problems in the use of QA data, particularly in the initial evaluation period. The base period subcategory error rates do not reflect the results of the RO subsample review. However, effective April 1, 1989, HCFA will implement the modernization of the QA program. The modernization will alter the method of sample selection, the equation for calculating error rates, the specificity of data available on the results of RO subsample review, and the classification matrix.

Some of these changes, such as the changes in the error matrix and availability of RO subsample review results on an error subcategory level will affect all carriers equally. Thus, although these changes may influence the reliability of this aspect of the evaluation with regard to the magnitude of the changes in error rates, it should not impact on comparisons among the carriers. Further, use of a rolling base period will eliminate this concern in subsequent period evaluations.

Other changes inherent in the modernization, such as revision in sample selection and error rate calculation will not impact carriers equally. However, these revisions will most directly effect the overall error rate determination rather than the individual subcategory error rates used in this portion of the evaluation.

Further, we expect the transition will impact on claims processing quality. Isolating this will be particularly difficult given that baseline data will be derived from Prudential rather than the carrier itself. The comparison between Aetna Georgia and Equicor North Carolina, however, should serve to isolate somewhat the effect of transition. Assuming that the project is extended beyond the initial 9-month period, we will conduct dual baseline comparisons in out years to further attempt to control for unavoidable situational influences on the data. That is, we will compare current period data to both the initial base period and the previous period data (rolling base).

Since RO findings in reviewing carrier QA subsamples are taken into account in calculating QA error rates, it is not necessary to further validate the data used in this portion of the evaluation.

Not all QA error subcategories are equally influenced by the medical review practices of the carrier. Thus, in addition to evaluation of the overall error rates, we will supplement the analyses with an investigation of certain individual error subcategories in an effort to ascertain the extent QA error variances are influenced by subcontracting medical review.

Data necessary for conducting such analysis will be gathered from the quarterly QA reports in CO. Additional reports from the carriers or ROs will not be necessary. Since under the modernization RO subsample review findings for individual error subcategories will be reported to HCFA, it is not necessary to further validate carrier submitted data.

We have identified the following subcategories for individual analyses of QA. These categories and the variables to which they refer in Table 1 Matrix of Proposed Changes in Error Subcategories, are as follows:

Category 2, Coverage will identify errors in the following subcategories: Covered services denied (HCFA mandated), Noncovered service allowed (HCFA mandated), Covered service denied (carrier guidelines), Noncovered service allowed (carrier guidelines), and Violation of utilization review parameters.

Category 5, Documentation will identify errors in the following subcategories: Required medical review not done, Payment or denial without medical evidence of need, Diagnosis missing or questionable, Identity of referring physician missing or questionable, and Failure to develop for clarification of procedure.

Admittedly, the use of a revised error matrix with the onset of the modernization will somewhat flaw these comparisons with the base year data. We will attempt to minimize this methodological problem by comparing current data with the past QA error subcategory(ies) that most nearly approximate the condition. Again, the impact of the modernization should effect each carrier involved fairly equally. Therefore, we do not find the complications insurmountable.

3. Medical Review

The flexibility carriers and Aetna Georgia will not be scored on the CPEP standards for medical review for purposes of calculating performance scores. Since the subcontractor is performing the preponderance of the medical review function in total, we believe the above evaluation of the medical review process and evaluation of effectiveness of that process serves to measure the impact of subcontracting in this area. Each of the CPEP standards has been included in the appropriate aspect of the MR/UR evaluation. Therefore, no additional analysis is required in this functional criterion.

4. Medicare Secondary Payer

It is not likely the subcontracting of the medical review function will effect a carrier's ability to achieve its MSP savings goals. Therefore, we have not planned a formal evaluation in this regard.

5. Pricing and Coding

It is not likely that subcontracting medical review would affect a carrier's performance in determining reasonable charges or related duties. We will, nonetheless, review all participating carriers' CPEP scores in this area.

6. Financial Management

Standard 5 of this functional criterion requires proper expenditure of payment safeguard funds. ROs should determine the percentage of program safeguard funds expended in accordance with the method of evaluation in section 5261.6 of the MCM. ROs should report the actual percentage, along with any narrative explanation for aberrant spending, for each of the participating carriers to CO in the comprehensive report for each fiscal period the project remains in effect.

In addition, percentages should be determined for the initial four months of the project by dividing the expenditures from the period January 1, through April 30, 1989 by one fourth of the approved NOBA. The results of this calculation should be forwarded to CO by May 31, 1989. We recognize that monthly expenditures are likely to vary seasonally and that such quarterly comparisons may not closely approximate prorated annual budgets. However, such a comparison will provide a rough approximation of spending for use in the initial evaluation.

Subcontracting could potentially influence the carrier s general financial management also (Standards 1 and 3). In conducting its annual CPEP reviews, the RO should be aware of this possibility and specifically note instances where subcontracting contributed to a finding. This information should be compiled and forwarded to CO. In order to ascertain the involvement of the subcontractor in performance, it is necessary for Aetna to establish a process to log the activities of HCC. That is there must

be in place a means to verify if violations of bank agreement and/or over expenditures are caused by the subcontractor. The RO should insure that this mechanism is in place prior to January 1, 1989.

Further, in evaluating standard 1, ensure that costs are allowable, allocations are consistent and appropriately charged, the RO should be particularly aware of the subcontract involvement. To the extent that it notes any impact of subcontracting on the carrier's performance, the RO should include it in the descriptive report and forward it to CO.

7. Beneficiary and Provider Services

A. Inquiries

Subcontracting the MR/UR process may potentially impact upon the carrier's performance in handling beneficiary and provider inquiries. For example, the MR/UR process can impact upon the workload (volume) of inquiries and accuracy and timeliness of responses in that it may be necessary to secure information from the subcontractor in order to respond.

Aetna Georgia's performance on Standard 6 - Respond accurately to correspondence, and Standard 8 - Respond timely to all correspondence is related to the subcontractor to the extent they relate to denials based on medical necessity.

In order to measure the impact HCC will have on the above standards, the ROs will need to be particularly aware of HCC's performance on the MR related cases occurring in its review of the sample selected for CPEP review. In order to assess accuracy, the responses must provide correct Medicare policy and contractor data and address major concerns expressed in the letters. Implied requests for reviews are a major concern and must be recognized and processed. Potential fraud and abuse correspondence must be recognized and properly referred.

Timeliness of responses are measured based on the same sample drawn for standard 6 above. Timeliness is measured based on the date of receipt in the corporate mailroom. A final written reply must be made within 30 calendar days from receipt of the inquiry. Participating carriers may need to establish a system for controlling referral of inquiries to the MR department for input or documentation if they do not as yet have such a control mechanism so that the impact of MR on timeliness can be assessed.

The RO will need to prepare a special report to include the total number of MR related correspondence, whether MR department/subcontractor input was necessary, and whether the response to the inquiry was timely and accurate. This review and report should be performed on all participating carriers so that comparison data is available. The report should be included in the comprehensive report and forwarded to CO by October 31 each year.

While we are equally concerned with the potential impact of subcontracting on responding to telephone and walk-in inquiries, these are not currently included in the CPEP standards.

B. Reviews and Hearings

Subcontracting the MR/UR processes potentially could be very influential on the carrier's review and hearing performance. To the extent that new policies have not been appropriately disseminated or are inaccurate, the review and hearings workload could increase. Likewise, to the extent that increased professional relations occurs and providers understand the rationale for a decision, workload volume could be expected to decline.

Further, the subcontractor could influence the timeliness of reviews and hearings through its involvement in the process. To the extent input is supplied in a timely manner the process could improve or performance issues may arise.

In conducting its evaluation of reviews and hearings for CPEP purposes, ROs should be particularly attentive to the impact of the MR processes on the quality and timeliness of reviews and hearings. Where MR referrals have affected the review or hearing process either positively or negatively, ROs should prepare a detailed narrative describing the condition. Data from the special appeals reporting should be used to supplement the analysis to ascertain the volume changes and their impact on quality and timeliness of review and hearings. The findings from this evaluation should be included in the comprehensive report and submitted to CO by October 31 annually.

B. Reporting

Standards 10 and 11 of the Reporting section of CPEP require the accurate and timely submission of Quarterly Medical Review reports. The

requirement for accuracy requires that carriers' MR reports be prepared in accordance with instructions, describe screens and their parameters, have accurate CMP or sanction savings in part IV, contain OIG documentation, and contain correctly calculated data. The timeliness standard requires that reports be submitted no later than 45 days after the end of each quarter of the fiscal year. ROs should assess the role of HCC and the MR department regarding timeliness and accuracy of the quarterly MR report during its CPEP review and prepare a report of its findings for the comprehensive report.

While Aetna will be responsible for the submission of this report, it will be necessary to know that HCC has furnished necessary data to Aetna and has done so timely. The RO should assure prior to January 1, 1989 that HCC has the ability to gather the data necessary to Aetna's submittal of the report. Aetna should maintain a log of the dates of information submitted so that responsibility for failure of this standard can be assigned to the appropriate party.

We believe that the carrier's medical review process should not impact upon CPEP standards for reporting, other than timely submission of medical review reports. Should Aetna Georgia experience performance problems or high achievement in other reporting standards which it believes have been influenced by the subcontract, we would consider any available data in attempting to evaluate the allegation. Therefore, Aetna should establish an ongoing mechanism of tracking requests and receipt dates for information exchange with HCC which is necessary for accurate and/or timely completion of HCFA-required reports.

9. Fraud and Abuse

In CPEP standard 1 and 2, detecting and developing fraud and abuse, the role of HCC and the MR department of control carriers will need to be evaluated. As a part of the CPEP review of the fraud and abuse area, ROs should make special note of HCC's and the MR department's role in each case. Where they had an impact, it should be summarized and evaluated. The evaluation report should be submitted to CO in the comprehensive report.

10. Management of Change

The subcontract relationship may impose some liabilities in meeting some of the significant changes the program experiences. To the extent these changes occur in MR related areas or other areas where Aetna and HCC must work together to accomplish the necessary goal, it will be important to note the process and effectiveness of the subcontractor in comparison to the MR department under common management.

This part of the evaluation can only be done where there are items affecting MR/UR or data interface with the MR department on the Critical Task List, Contractor Workload Management System List, or RO directives. In those instances the ROs will perform a retrospective review of how the

task was accomplished and whether it was done accurately and within assigned timeframes. ROs should notify CO as soon as they become aware of MR related items subject to this standard, so that all ROs can be advised to conduct comparable reviews of the carriers in their region.

ROs should summarize their assessment findings in the comprehensive report to CO.

11. Comprehensive Report

Upon completion of all performance reviews, ROs should submit a narrative comprehensive report for all participating carriers and Aetna Georgia on their findings and recommendations. The format of the report is somewhat discretionary with the RO. However, as a minimum, it should include narrative descriptions of findings in the following areas: policy development evaluations (1990 and following years), postpayment processing, results of sample reviews for MR accuracy, attestation of validation of carrier's MR savings, supplemental cost report, summary of MR/UR administration (1989) and changes occurring throughout the year (1990 and following years), and results of provider survey (1990).

Further the comprehensive report should summarize the MR interaction and its effect on carrier operations and performance in unit costs, financial management, beneficiary and provider services, reporting, fraud and abuse, and management of change.

We have not anticipated an impact on several areas of carrier operation as a result of subcontracting. ROs are requested, however, to subjectively assess the interrelationship with the MR/UR department or subcontractor during their performance reviews. All areas of impact, positive as well as negative, should be noted throughout the year as RO review carrier operations.

This report must be forwarded to CO by October 31 each year.

SUMMARY OF DATA NEEDS/ANALYSIS

Element	Data Source	Review Period	Submission Date to CO
Policy Development	RO Report	April '89/Open aft	May 31,'89/Oct 31
	Quarterly MR Rpt	Each Quarter	45 days after qtr
Post Payment	RO Report	RO discretion	Oct 31 Annually
	Annual Management Report	Fiscal Year	Nov 15
	Quarterly MR rpt	Quarterly	45 day after qtr
Effectiveness			
Accuracy	Sample claims rev	Fiscal Year	Oct 31 Annually
	QA coverage error	Fiscal Year	not applicable
	Appeals Reversals	quarterly sample	30 days aft qtr
Savings	RO Validation Rpt	Dec '89/open aft	Jan 31'89/Oct 31
Cost Avoidance	Carrier Calculation	Fiscal Year	Dec 31 Annually
Costs	Supplemental Cost Report	Oct 1-Apr 30, 1989	May 31, 1989
		Fiscal Year	Oct 31, 1989 (subsequent years)
Environment			
Inquiries	Change in MR Inq. Report	Baseline sample	Jan 31, 1989
		quarterly sample	30 days aft qtr
Appeals	Change in Appeals Report	Baseline Sample	Jan 31, 1989
		quarterly sample	30 days aft qtr
Providers	Survey	Apr 1990	Oct 31, 1990
Administration	RO Report	Apr '89/open aft	May 31'89/Oct 31
Subcontract			
Unit Cost	IER	Fiscal Year	Oct 31 Annually
Claim Proc	CPT Reports	monthly	not applicable
	MR Time Rpt	monthly	monthly
	QA Analysis	Fiscal Year	not applicable
Financial Mgmt	Percent of NOBA Expended	Apr '89/FY aft	May 31'89/Oct 31
Bene/Prov	MR Inquiries	Fiscal Year	Oct 31 Annually
	MR Appeals	Fiscal Year	Oct 31 Annually
Reporting	Quarterly MR Report	Fiscal Year	Oct 31 Annually
Fraud & Abuse	RO Review	Fiscal Year	Oct 31 Annually
Mgmt of Change	RO Review	Fiscal Year	Oct 31 Annually

EXHIBIT A

Sample Period_____

I. REVIEWS
- a. Number of reviews requested_____
- b. Number of reviews sampled_____
- c. Number of review requests related to medical necessity_____ (Identify screens as an attachment)
- d. Number of reviews requested related to MR which were reversed_____
- e. Number of MR related reversals based on new information_____
- f. List MR issues appealed

II. HEARINGS
- a. Number of hearings requested_____
- b. Number of hearings sampled_____
- c. Number of hearing requests related medical necessity_____ (List issues as an attachment)
- d. Number of hearings requested related to MR which were reversed_____
- e. Number of MR related reversals based on new information_____
- f. List MR issues appealed

Instructions

Line a - Enter the total volume of reviews and hearings for the sample periods, i.e., the number of cases since the previous sample period.
Line b - Enter the total number of reviews and hearings sampled.
Line c - Enter the number of sampled cases where one or more issues was related to a partial or total denial or reduction based on application of MR processes, including failure to submit necessary documentation.
Line d - Enter the number of sampled cases related to MR issues where the decision reversed the carrier's initial determination.
Line e - Enter the number of MR related sampled cases where new information was presented during adjudication which may have contributed to reversal.
Line f - List the issues involved in the MR related appeal cases sampled.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8

Portion 1 - No Billing Allowed

Procedure Code	FY 1988 Frequency	Inflation Factor	Expected Frequency	Observed Frequency	Reduction	Processing Cost	Cost Avoidance

Portion 2 - MR Screen In Effect

Procedure Code	FY 1988 Frequency		Inflation Factor		Expected Frequency		Observed Frequency		Reduction or Difference		Average Allowable Charge		Cost Difference
Example:													
36830	500	X	1.05	=	525	-	400	=	125	X	$50.00	=	$6250.00

Portion 3 - Code Shifting

Procedure Codes Identified for Modification	New Procedure Code

Procedure Code	FY 1988 Frequency	Inflation Factor	Expected Frequency	Observed Frequency	Increase/ Decrease	Average Allowable Charge	Cost Difference

To calculate cost avoidance for each procedure (column 8), multiply column 3 by column 2, then multiply column 7 by the difference between columns 4 and 5 (column 6).

Exhibit C

MR Flexibility Supplemental Cost Report	The First Two Calendar Dates of Cumulative Reporting Periods:	Date that this report is due:	Enter this report's calendar date:
Contractor Number = _____	1. Oct. 1, 88--Apr. 30, 89	May 31, 89	_____
Contractor Name = _____	2. Oct. 1, 88--Sep. 30, 89	Oct. 31, 89	

MR/UR Activities (A)	Productive Hours (B)	Personal Services (C)	Subcontracts (D)	All Other (E)	Total (F)
Costs from IER Line 5:					
1 Startup Costs					
2 Policy Development					
3 Professional Relations					
4 Category I					
5 Post-Payment					
6 Fraud & Abuse					
7 Special Projects					
8 Routine Operations					
9 EDP Costs					
10 Overhead Costs					
11 Other Costs (Identify)					
12 Other Costs (Identify)					
Total Cost (add Lines 1-12)					
13 From IER Line 5:					

Note: Total Cost and Line 13 must be equal because they're measuring the same costs.

14 Costs Not From IER Line 5					

Startup Costs: Recruitment and training costs, space and utility acquisition.

Policy Development: New screens analysis, consultations, development and preparation of guidelines, systems modifications testing.

Professional Relations: Travel, newsletters, workshops, meetings with associations.

Category I: Front-end review and resolution of MR claims.

Post-Payment: Integrity review, data analysis, corrective action, workload reporting, and related overpayment activities.

Fraud & Abuse: Documentation and analysis related to OIG referrals (sanction and CMP cases)

Special Projects: Any special medical review projects.

Routine Operations: Category II and III screen activities.

EDP Costs: An allocation of EDP costs for MR/UR.

Overhead Costs: An allocation of overhead costs for MR/UR.

Costs Not From IER Line 5: Any MR-related costs that may be reported in the IER on lines other than Line 5.

Put remarks, if any, on a separate page.

EXHIBIT D

Identify Sample Period_____

		Telephone	Written	Walk-in
I.	PROVIDER INQUIRIES			
	a. Total number received	_____	_____	_____
	b. Number of Inquiries Sampled	_____	_____	_____
	c. Number MR Inquiries Sampled	_____	_____	_____
	d. Number referred to MR Department	_____	_____	_____
II.	BENEFICIARY INQUIRIES			
	a. Total number received	_____	_____	_____
	b. Number of Inquiries sampled	_____	_____	_____
	c. Number MR inquiries sampled	_____	_____	_____
	d. Number referred to MR Department	_____	_____	_____

III. SIGNIFICANT MR ISSUES

_____
_____
_____
_____
_____

Instructions

Carriers should complete all three columns for each line item.
Line a - Enter the total volume of workload for the reporting period, i.e., volume of inquiries since the last sample period.
Line b - Enter the total number of inquiries sampled.
Line c - Enter the number of sampled cases that presented an MR issue. MR issues include questions related to MR policy in general, as well as questions related to claims with denials or reductions as a result of application of MR policies.
Line d - Enter the number of sampled cases that had been referred to the MR Department for assistance or response.

Mr. WAXMAN. I would like to now call forward Susan A. Stallings, manager, Savannah, GA, Aetna Insurance Co., who will be accompanied by Robert S. Champagne, director, part B Medicare; Margaret Diener, vice president of operations, HealthCare COMPARE.

We are pleased to welcome you to our subcommittee meeting this afternoon. Your prepared statements will be in the record in full. We would like to ask, if you would, to limit your oral presentation to no more than 5 minutes.

Ms. Stallings.

STATEMENTS OF SUSAN STALLINGS, MANAGER, AETNA-MEDICARE PART B, SAVANNAH, GA, ACCOMPANIED BY ROBERT CHAMPAGNE, DIRECTOR, MEDICARE ADMINISTRATION'S AETNA LIFE INSURANCE CO.; AND MARGARET DIENER, VICE PRESIDENT OF OPERATIONS, HEALTHCARE COMPARE

Ms. STALLINGS. Thank you, Mr. Chairman and members of the subcommittee, Dr. Rowland, we appreciate the opportunity to discuss Aetna's role as the Medicare administrator for the State of Georgia.

I am Susan A. Stallings, office manager of the Aetna operation in Savannah, GA. My office is responsible for processing Medicare part B claims for the State of Georgia.

With me is Robert Champagne, the director of Medicare part B administration for Aetna out of Hartford, and next to Bob is Margaret Diener, the Vice President of Operations for HealthCare COMPARE, our medical review subcontractor.

We have submitted a statement for the record and I will just summarize some of the points that are highlighted in that statement.

When Aetna was awarded the Georgia Medicare part B contract in June 1988, we faced the challenge of a lifetime. But I am pleased to say that we have more than met this challenge according to Georgia beneficiaries and various reviews that have been conducted in our office.

As you heard earlier today, the Office of the Inspector General recently completed a survey of Georgia beneficiaries to measure their satisfaction with our services. The figures show that 85 percent of the Georgia beneficiaries are satisfied with the way Aetna has processed their Medicare claims and that 83 percent believe they get information about Medicare when needed. These results are on par with the national average for all part B carriers and we are pleased because they are more impressive considering that Aetna's performance was measured during a transition year that witnessed a first-in-the-Nation pilot program with a brand new staff.

A second part of the OIG review involved an independent audit of a random selection of claims reviewed by HealthCare COMPARE. This audit found that Aetna and HealthCare COMPARE have done an outstanding job in paying Medicare part B claims in Georgia, according to the rules and regulations of HCFA.

Aetna has served the program since Medicare's inception in 1966. As a part B carrier, Aetna serves nearly 2 million benefici-

aries in eight States. Combined with our part A hospital insurance operation, Aetna disburses $7.2 billion annually in Medicare part A and part B benefits. We employ 1800 people countrywide to manage this responsibility.

Aetna's role as a Medicare part B carrier is to process Medicare claims under the rules and standards set forth by Congress and put in place by HCFA. We carry out this function according to the terms and conditions of the contract with the government.

As stated before, Aetna makes no profit from its Medicare contracts. We are reimbursed by the government for the administrative expenses we incur in processing Medicare claims. Neither Aetna nor HealthCare COMPARE receives any compensation for the dollar results of our work. There are not financial incentives to reduce or deny Medicare payments.

After the prior carrier announced it would totally withdraw as the Medicare part B carrier as of January 1, 1989, HCFA had only 6 months find and establish another Medicare contractor for the State of Georgia. Aetna responded to this call and was awarded the contract on June 10, 1988.

HCFA required Aetna to hire an independent organization to provide health care utilization review services. Georgia is the only State where a third party independent review is required. We chose HealthCare COMPARE as our subcontractor for its experience and expertise in medical review, its willingness to enter into a cost reimbursement contract and its commitment to locate staff at our Savannah facility, which we felt was very important since this was a pilot project.

We focused all valuable resources to make our Savannah, GA office operational as quickly as possible. Everything of course was new. Our staff was new, our office site was new, our equipment was new, et cetera. All of this had to be in place in a scant 6 months. So we drew on the experience of our core staff of Medicare managers, supervisors and other specialists nationwide to help with the transition.

We even agreed to process the prior carrier's claims in the fall of 1988 in order to familiarize ourselves with the process and to reduce as much of the backlog we would eventually inherit. We had expected a backlog of 400,000 claims, but the inventory we assumed on January 1 amounted to nearly 600,000 claims. We even worked January 2, which was a New Year's holiday for everyone else, in order to get a head start on the transition. To do the job as well as we could, we hired an additional 50 personnel above and beyond the number allowed in our original HCFA contract, at a corporate expense to Aetna of $500,000.

But through the hard work, lots of overtime and staff additions, our dedicated staff reduced our pending claims to a more acceptable level.

We now process Georgia Medicare part B claims three times faster than during the beginning stages of our transition. Each month, we process on average 750,000 claims and pay $49 million in benefits. That is about 9 million claims and $590 million in benefits annually, just for Georgia.

We have worked hard to perform our Medicare duties according to the rules and regulations of HCFA. In addition to our day-to-day

responsibilities we see our role as helping the government carry out the will of Congress to administer the Medicare part B program in a fair and equitable manner for the Medicare beneficiaries. It is our job to pay all of Medicare's fair and legal share of a claim, but no more. We must pay close attention to the appropriateness and medical necessity of health care services in order to help the government identify and curb overpayments and potential abuses in the Medicare program. We therefore support responsible efforts such as HCFA's pilot program for Georgia, to help control Medicare costs and protect the financial integrity of Medicare. It is not our job to be an easy touch and to pay anything that comes in the door with no questions asked.

Because of the up front transition problems we encountered and because of the newness of the HealthCare pilot we took some extra steps to be more public about our role. We established a congressional assistance unit and instituted a congressional hotline, which I am pleased to say that most comments and feedback we have gotten has indicated it is working very well.

We formed an advisory group, meeting regularly with HCFA representatives, Georgia physicians and other provider representatives to address problems. We established a monthly newsletter, which communicates program guidelines and we placed onsite claims representatives in Atlanta and Macon, in addition to our three representatives that work out of Savannah.

In short, we are very proud of the responsible and professional way our Georgia employees have handled their job. We are carrying out our duties as intended by the laws and regulations controlling Medicare which we faithfully follow. And if government issues new laws and regulations, we would follow the new rules as well. But we are not in any position to change them on our own, as only government can change the rules.

We had some startup problems, compounded by several unique factors beyond our control, but we are doing a good job at what we have been hired to do.

Margaret Diener will now speak to the role of HealthCare COMPARE.

Mr. WAXMAN. That is fine.

[Testimony resumes on p. 213.]

[The prepared statement of Ms. Stallings follows:]

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Susan Stallings, Office Manager of the Ætna Life Insurance Company's Savannah, Georgia Medicare office. This office is responsible for processing Medicare Part B physician claims on behalf of the Health Care Financing Administration for the entire state of Georgia. With me is Robert Champagne, who is Director of Medicare Part B Administration for Ætna in Hartford, Connecticut. Bob is responsible for managing Ætna's Part B Medicare activities throughout the country.

We appreciate this opportunity to discuss Ætna's role as Administrator of Medicare Part B, particularly in the state of Georgia and to answer your questions on the service we provide and the role we play in Medicare.

BACKGROUND

Ætna's Medicare involvement is handled by Ætna Life Insurance Company (Ætna), which is an operating company of its parent, Ætna Life and Casualty Company. Both are headquartered in Hartford, Connecticut with branch offices and local operations throughout the country. Ætna has served Medicare since the program's inception in 1966. As a fiscal intermediary under Medicare Part A, Ætna currently serves nearly 3,000 hospitals, skilled nursing facilities, and home health agencies

throughout 43 states. As the payment processing carrier under Medicare Part B, Ætna serves nearly 2 million beneficiaries as the Administrator of physician payments in 8 states. Combined, Ætna disburses $7.2 billion annually in Medicare Part A and B benefits on behalf of the Department of Health and Human Services. Ætna employs 1800 people countrywide to manage this responsibility (600 for Part A; 1200 for Part B).

To be selected as a carrier under Part B requires the prospective entity to satisfactorily meet the high standards set forth by the Health Care Financing Administration (HCFA) and to comply with the terms and provisions of a formal contract specifically setting forth the selected carrier's duties and responsibilities.

Ætna makes no profit from its contracts with the government to serve as Part B Administrator and this of course includes our contract for the State of Georgia. Such contracts are usually written on a yearly basis. Reimbursement is based on a carrier's cost for administrative services as approved by HCFA. These cost arrangements are negotiated in advance with HCFA and can be modified only with HCFA approval.

Ætna originally elected to participate as a contractor in Medicare since we felt strongly that the private sector, experienced in health care programs, could offer the government valuable expertise and experience in claim

processing. Further, as a leader in health insurance and claims payment processing, Ætna has always looked for ways to share our technology particularly where we could as well demonstrate our commitment to good corporate citizenship.

Throughout Ætna's 24 years in Medicare, we have fully and capably carried out HCFA's guidelines and directives. As is the case with all carriers serving the Medicare program, Ætna is routinely audited by HCFA and other government agencies, and we have continuously and consistently been highly rated by HCFA for our Medicare performance. As well, Ætna enjoys a tradition of being responsive to both the beneficiary and provider communities.

For example, in 1986 Ætna was selected to take over the Medicare Part B administration contract for the state of New Mexico. This transition was accomplished in an exemplary manner with recognition of this achievement from both HCFA and the state medical association (see enclosures).

GEORGIA

In May of 1988, the Prudential Insurance Company of America (Prudential) announced its intention to totally withdraw as the Medicare Part B carrier in Georgia and two other states (New Jersey and North Carolina) as of January 1, 1989; the announcement was a surprise to all. Prudential further

indicated that it would divert its Medicare Part B staff in Georgia to private sector activities rather than make this staff available for hire to the succeeding carrier (which in many cases is what happens with a change in carriers).

Right after the Prudential announcement, HCFA solicited Ætna and other experienced carriers to submit brief proposals to serve as the Part B carrier in at least one of the 3 states vacated by Prudential. With a more normal lead time of one year HCFA would have been better able to more formally seek out bidders; however, they had no choice but to proceed as quickly as possible to put a new carrier in place as of 1/1/89. Ætna responded to HCFA's request with a formal offer in May, 1988 to serve as Part B carrier in Georgia. After several negotiating sessions a formal contract was executed in June, 1988, which was when Ætna was first able to really begin the process of taking over the state. Even under the best of circumstances the six months remaining until the 1/1/89 Prudential withdrawal date would <u>not</u> have been adequate to allow a new carrier to assume its duties as Administrator.

Adding complexity to the transition was the fact that in Georgia, HCFA required Ætna to hire an independent organization to provide health care utilization review services. Thus, our proposal to be the Part B carrier in Georgia had to include the use of a third party subcontractor to conduct independent utilization review in order to gain

HCFA approval. Georgia is the only state where this demonstration was required. All other carriers in the country are responsible for performing their own medical review activities under Part B.

Aetna contacted several independent utilization and managed care organizations and selected HealthCare Compare (Compare) of Downers Grove, Illinois to perform this HCFA-required review function as a sub-contractor of Aetna. Our reasons for selecting Compare were:

- Compare's experience and expertise in medical review.
- The availability of physicians, nurses, and para-professionals within Compare's organization.
- Compare's willingness to enter into a cost reimbursement contract (although this was not a HCFA requirement).
- Compare's commitment to locate its staff in Aetna's Savannah, Georgia facility.

Aetna's proposal to serve as the carrier for Georgia, including the sub-contractor arrangement with Compare, was submitted to HCFA in May, 1988, barely one month following Prudential's

notice of intended departure. On June 10, 1988, HCFA announced that Ætna was awarded the contract to serve as the Medicare Part B carrier for Georgia.

Prior to its selection by HCFA, Ætna took steps to expedite the process believing that if selected we would need all the lead time possible. For example, we initiated a demographic and site survey in Georgia. It was Ætna's intention to keep the Medicare operations within the state of Georgia rather than have Georgia's claims sent to one of Ætna's existing Medicare offices in Phoenix, Oklahoma City, or Portland, Oregon.

Had Prudential made its Georgia staff available, Ætna would have made every effort to hire most if not all of the 300 Prudential incumbents; furthermore, we would have willingly assumed Prudential's lease in Buford, Georgia and retained this facility as our Georgia site of operations. In many transition situations, it is practice to have the incumbent staff absorbed by the new contractor; this is what recently occurred in Connecticut and Kentucky.

However, since Prudential retained all of its staff for other Prudential purposes, we looked elsewhere for a local site and ultimately decided to locate in Savannah. A workforce was available, and Ætna located a 50,000 square foot facility that could be readied for occupancy by October 1, 1988.

During the period of July through September 1988, Ætna focused its resources on making its Savannah office operational in terms of renovations to the building, procurement of office equipment and supplies, and installation and testing of data processing equipment. Also during this period, Ætna drew on the experience of its core staff of Medicare managers, supervisors, and other specialists throughout the country to help with the transition. We even recruited and transferred many of these employees from our other Medicare and private sector claims offices. Advertising and recruitment in the Savannah area for 330 positions was also initiated. Nearly 2000 applications were received.

The office officially opened on October 1, 1988, 3 months before Ætna's contract was to commence (on January 1, 1989). An enormous challenge faced the office: equipment had to be delivered and made functional; work flow had to be established; processors, telephone agents, mail staff, etc. had to be trained; communications programs had to be undertaken and data processing files converted from Prudential to Ætna formats.

It was impossible to have all staff report on one day. This would have involved 330 Ætna staff and 48 Compare staff; consequently, incremental staff segments reported pursuant to

an established schedule: 100 in early October; 100 in November, etc. Those positions requiring less demanding skills reported last.

Training was intensive. Inexperienced employees were confronted with absorbing a complex medical program in a high-tech environment. Medicare procedure and terminology training occurred to develop a working knowledge of claim processing skills such as the handling of end-stage renal disease, anesthesiology, internal medicine procedures, secondary payer rules, durable medical equipment rules and cataract surgery claims. This list is a mere fraction of the technical knowledge that had to be absorbed.

In order to facilitate training, Ætna agreed to process certain claims for Prudential prior to Ætna's actual January 1, 1989 takeover. Although processing was not in an on-line interactive environment with Prudential's main frame terminals, it was helpful for training purposes by familiarizing Ætna's staff with actual Georgia claims and in reducing the backlog that Ætna would eventually inherit from Prudential.

Prudential commenced its phase-out in mid-December 1988 and from that point, all pending claims (i.e., in process claims) plus new incoming claims belonged to Ætna.

On January 1, 1989, our inventory of pending claims was 589,000; we had expected no more than 400,000. Our staff even worked on Monday, January 2 -- New Years holiday for everyone else -- to get off to a good start.

The high number of inherited pending claims together with an exceptionally high number of new claims (all of which were being handled by a relatively inexperienced staff), caused a serious backlog to develop. This backlog rose to a high of 850,000 claims in mid-February. Some system problems also surfaced as the capacity of activity taxed our computer ability to timely handle all transactions. Obviously, during these early 3 months, Ætna's phones were inundated with calls; claim status inquiries multiplied.

Notwithstanding these upfront transitional problems, the Ætna team, which includes the staff of Compare, was determined to turn it around as quickly as humanly possible. Through hard work, lots of overtime, staff additions, other Ætna office assistance and strong management direction, Ætna was able to reduce the pending claims to more acceptable levels in April, May, and June 1989. Other areas of program responsibility also reflected improvement in the areas of correspondence, claims reviews and telephone inquires. To do the job right, we even hired an additional 50 personnel above and beyond the number allowed in our contract at a non-reimbursed (from HCFA) corporate expense to Ætna of $500,000.

In summary, Ætna now processes Georgia Part B claims 3 times faster than during the transition period (1st quarter, 1989). Each month we process roughly 750,000 Medicare claims and pay $49 million in benefits to physicians and beneficiaries. That's about 9 million claims and $590 million in benefits annually just for Georgia. Our internal quality checks indicate that 97%-99% of our claims are processed accurately and over 95% are processed within 24 days. We've increased phone service to the extent that 99.9% of Medicare beneficiaries get through without a busy signal and 95% reach an Ætna person within 120 seconds--no small feat when we receive 2000 calls per day. And we do our job in Georgia on a not-for-profit basis, i.e., we are reimbursed for the administrative expenses we incur (as approved by HCFA) and no more. Neither Ætna nor Compare receives compensation for the dollar results of our work; there are no financial incentives to reduce or deny Medicare payments.

THE REVIEW PROCESS

In applying fundamental claim processing controls, proven utilization review techniques and in general administering the program in accordance with prescribed HCFA directions, both Ætna and Compare are carrying out the duties we have been assigned by HCFA. In addition, we are helping government to identify and curb overpayments or potential abuses of Medicare

Trust Fund money as part of government's cost-containment efforts. It is our view that we have a responsibility to beneficiaries, physicians, HCFA and the Congress to follow the rules and pay all that Medicare owes but only what Medicare owes. It is not our job to be an "easy touch" and to pay with no questions asked. We therefore support responsible efforts to help control Medicare costs and protect the financial integrity of the program.

This concern for cost-containment and a desire to more closely monitor the medical review process led HCFA to improve Medicare's utilization review process by requiring Ætna to hire a third party review sub-contractor to monitor medical necessity and appropriateness of health care services based on HCFA guidelines.

Under Ætna's management, we review claims (in Georgia and elsewhere) for many reasons; a partial list follows:

- Are the claims duplicates of previously submitted billings?
- Should Medicare be the primary carrier?
- Is the charge reasonable?
- Is the claim coded properly?

- Was the beneficiary covered when the service was rendered?
- Is the diagnosis included?
- Is the service covered under Medicare?
- Is the claim timely submitted?
- Is the physician properly using the assignment agreement?
- Is the physician billing within Maximum Allowable Actual Charge (MAAC) limits?
- Is the claim form complete?
- Was the injury occupational in nature?
- Is the physician certified?

Both Ætna and Compare adhere strictly to Medicare laws, regulations and to HCFA directives and guidelines. For example, because Congress has determined by law that working aged Medicare beneficiaries be covered <u>first</u> by their employer (and <u>secondarily</u> by Medicare) we monitor our processing to

ensure that Medicare Trust Funds are not spent on such beneficiaries until after the employer's coverage has been utilized. We also have to react to items such as budget reductions, e.g., Medicare budget reductions in 1989 caused Ætna (and other intermediaries/carriers) to reduce our Medicare staffs. And as well, we need to be alert to new legislative items (such as the physician payment reform passed in 1989) which will change the scope of Medicare and consequently the operation of Medicare Administrators.

Ætna and Compare can only carry out the program's directives; as with any carrier, we cannot and do not set program policy.

Notwithstanding the intensified medical review effort conducted by Compare, it should be noted that Compare reviews fewer than 8% of Ætna-processed Medicare Part B claims. And only about a third of Compare's review has resulted in a reduction or denial of claims. Yet from January 1989 through September 1989 Ætna, through Compare, saved the Medicare Trust Fund $15 million.

EXTRA STEPS FOR GEORGIA

Because of transition problems encountered in Georgia and and because of the newness of the Compare pilot program required by HCFA, we wanted to be public and available concerning the changes occurring in Georgia. For example, we established a Congressional assistance unit and instituted a Congressional hotline. We formed an advisory group which meets regularly with HCFA representatives, Georgia physicians and other representatives of the provider community to address concerns. We established a monthly newsletter to communicate program guidelines to physicians. And we placed on-site claim representatives in Atlanta and Macon.

In the first few months of 1989, Ætna participated in two Medical Association of Georgia panels with Georgia Congressional staff in attendance. On April 19, 1989 we met with six members of the Georgia Congressional delegation along with representatives of HCFA and Compare to discuss the transition. We have routinely corresponded with the entire Georgia delegation (including District offices) to inform all offices of the status of the case and on several occasions we have met with several members of the Georgia Congressional delegation to further answer questions on our role and/or to conduct tours of our facility.

Often we were criticized for various procedures, e.g., for slow payment or quality of the claim process. As previously indicated, steps have been taken to attend to and redress these problems. Our pending claims load has been reduced to acceptable levels and quality controls have been intensified.

Further, with respect to quality we have instituted a number of quality controls (retraining, supervisory audits, error feedback and progressive discipline) to continue improvements in this arena. In addition, the use of a special computer program to detect errors in multiple surgery, global changes, and other high error potential medical codes is being evaluated. If feasible, this computer monitoring program will be installed by May 1, 1990.

Notwithstanding the improvements made subsequent to the first quarter (1989) transition period, this relative progress has been attacked in a series of articles published in the Atlanta Constitution and the Atlanta Journal, starting November 5, 1989, and continuing into 1990.

In Ætna's opinion, this commentary was exacerbated by some in the medical community who were dissatisfied with HealthCare Compare and the demonstration project in general. They felt and continue to feel that Georgia physicians are being singled out for intensified scrutiny. The series of articles also utilized a number of anecdotal incidents involving mishandling

of beneficiary claims. Most unfairly, a poll was undertaken soliciting those "who had problems" with Medicare to call an Atlanta Constitution hotline to register complaints; they weren't asked to register compliments. More than 3,000 called and the Constitution used this survey as a barometer of Aetna's effectiveness. Aetna staff met with the editorial boards of the Journal/Constitution to present its side of the issue and to object to the unfairness of the poll and the misleading nature of some of the stories. Reporters were invited to visit our facility; this offer was never accepted.

From a question of balance, we think that an article that appeared in The Wall Street Journal on December 29, 1989 (enclosed) offers a fair view of the situation.

As a result of the public and Congressional interest in this issue, a series of investigations or reviews has been initiated including a General Accounting Office Study (due out in the Fall, 1990) and a review conducted by the HHS Office of the Inspector General (OIG) at the request of HCFA.

The OIG has been asked to: (1) evaluate Aetna and the effectiveness of Compare; and (2) to measure the impact of the change of contractors on Georgia beneficiaries by comparing current beneficiary satisfaction with services provided by the Medicare Part B carrier in Georgia with a similar survey conducted nationwide in 1989 in order to determine if there

were significant differences. We feel confident that these findings will reflect the steady improvement demonstrated by Aetna and Compare over the past year.

Preliminary reports on the beneficiary satisfaction component of the OIG survey indicate that 85% of Georgia beneficiaries are satisfied with the way Aetna has processed Medicare claims, which compares favorably to the nationwide satisfaction rating of 88%. It should be noted that the Georgia-only survey (conducted in December, 1989) reflects Aetna's performance with a brand new staff during a transition year that witnessed a first-in-the nation pilot program involving a third party reviewer. Furthermore, the transition itself occurred at the end of a calendar year, which is not the best time for such a change in carriers.

We understand as well that the beneficiary survey demonstrates that the stories in the Atlanta papers influenced opinion. Thirty-nine percent of Georgia beneficiaries had seen newspaper articles critical of Aetna. The satisfaction rate of those who saw the articles was 72%; those who had not seen the articles expressed a 92% satisfaction rate.

We understand as well that the beneficiary survey also shows that 83% of Georgia beneficiaries (compared to 85%

nationwide) get information about Medicare when needed and that 73% of Georgia beneficiaries (compared to 74% nationwide) believe carriers pay claims quickly enough.

In all, these beneficiary survey results are a positive measure of the remarkable progress made by Ætna and Compare, and we look forward to the remaining part of the OIG study, which we believe will further affirm that we have correctly honored and abided by the rules of the program.

SUMMARY

In summary, when Prudential notified HCFA (Summer 1988) that it was withdrawing (as of 1/1/89) as Medicare Part B Administrator in Georgia, time didn't permit the full Request for Proposal that normally accompanies such changeovers. Instead, HCFA asked for help from various carriers and Ætna responded with a proposal to take over the Part B payment duties in Georgia...and agreed to utilize a third party reviewer (Compare).

However diligent we were in managing the transition, not everything worked precisely as planned in the beginning. Using our best efforts, Ætna has tackled every operational problem that has surfaced with enthusiasm and a dedication to do the job right. We are very proud of the responsible and professional way our Georgia employees have handled both their

jobs and the criticism directed at Aetna (which isn't the best medicine for morale among a new staff). We even hired additional personnel (about 50) above and beyond the number allowed in our contract with HCFA at a non-reimbursed corporate expense of $500,000.

In our view, Aetna is satisfactorily attending to its responsibilities as Part B Administrator for Georgia within the rules and guidelines provided by HCFA.

To compound the normal transition problems, the Georgia case has a unique aspect. HCFA used the changeover of carriers to implement a new way of handling claims. HCFA directed Aetna to hire a subcontractor to perform the utilization review function normally done by the insurance carrier administering the case. Aetna chose HealthCare Compare which has reviewed certain claims and made certain decisions (denials, reductions in amount) based on their expertise and according to HCFA guidelines.

There are two inter-related issues at work here: (1) How did Aetna handle the transition from Prudential? (2) How is HCFA, through Aetna and Compare, carrying out its overall mandate from Congress to pay all of Medicare's fair and legal share of a claim (and no more) and to pay attention to how it spends taxpayer money by closely monitoring the program? As for No. 1, we think that we are well over the rough spots of

transition and that we are satisfactorily attending to our duties as Administrator of Part B claims in Georgia.

As for No. 2 (which is the "cornerstone" issue), as the Part B Administrator in Georgia, the Aetna role is to carry out government's direction to closely monitor claims including the use of a third party medical review sub-contractor as part of a pilot government cost-containment program. As the "messenger" of the government's program, Aetna has improperly been cast as the villain at times seemingly by all parties. This is unfair as Aetna has made large strides to overcome whatever transition problems we've encountered. And of course the "cornerstone" issue is really more the doing of government than Aetna.

Simply stated, it is our view that:

- If Aetna and Compare are handling their duties contrary to the rules, then correct us or select another carrier.

- However, if we are correctly handling our duties according to the rules (as we believe we are), then stand by us...or change the rules through legislative action or governmental dictate.

- We're pretty good at what we've been hired to do. If Congress or HCFA would rather us to be an "easy touch" with taxpayer dollars, someone needs to tell us.

We want to thank the Subcommittee for this opportunity to present our views.

Testing a Plan, Medicare Pains Georgia Doctors

By JAMES R. SCHIFFMAN
Staff Reporter of THE WALL STREET JOURNAL

ATLANTA — Doctors in Georgia are guinea pigs of sorts these days, and they don't like it one bit.

The Health Care Financing Administration, which oversees Medicare, is using the state to try out a system of intensified scrutiny of doctors' charges, all in an effort to rein in costs. The result: Medicare claims are being denied, delayed and "downcoded," or reimbursed at lower rates than doctors expect. In some cases, doctors have had to refund money to patients.

"It's been a nightmare really," says Charles Harrison, an Atlanta internist who, like many compatriots, complains of extra paper work and the dread of having every move put under a microscope.

Nightmare or not, it could be a glimpse of the future for Medicare, the federal health-care insurance program for the elderly that pays about a quarter of the nation's doctor bills. The HCFA says the Georgia experiment is a pilot that may be extended, perhaps even nationwide.

Other states face cost-control tactics, too. The Medicare administrator in North Dakota is looking for ways to identify suspicious conbinations of procedures and diagnoses. In New York and Massachusetts, Medicare administrators write letters to doctors who perform more of certain procedures than is typical in those areas. "The intent is to change physician behaviors," says Barbara Gagel, director of the HCFA's bureau of program operations.

Basic numbers underscore the desire: Since 1965, Medicare payments for physician services in the U.S. have increased 77%, while the number of beneficiaries has risen only 8%.

The endeavor in Georgia is the most controversial so far. The experiment came about at the beginning of 1969 when the HCFA switched its Medicare administrator in the state. When the agency made the change, it decided to have the new administrator, Aetna Life Insurance Co., contract with an outside watchdog company to scrutinize suspect claims. Medicare is taking a tip from private insurers, which have used outside claims examiners for years.

Aetna chose HealthCare Compare Corp., a claims-scrutinizer based in Downers Grove, Ill. HealthCare Compare, which came on the scene in January, quickly began hitting Georgia physicians their pocketbooks by taking a jaundiced look at claims for "comprehensive" consultations.

Such visits should be rare because they

Please Turn to Page B3, Column 1

"Wall Street Journal" 12/29/89

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TECHNOLOG

As It Conducts Cost-Control Test, Medicare Pains Doctors in Georgia

Continued From Page B1

involve an intensive look at a patient, including the taking of a full medical history, says Robert J. Becker, a physician who is chairman of HealthCare Compare. Yet the HCFA's own statistics show that in 1987, Georgia doctors billed for comprehensive visits 23% more than the U.S. average.

The suspicion was that some doctors were "upcoding," or charging Medicare for comprehensive visits—at more than $100 a shot—when they should have been billing in the $30 range for simpler consultations.

In one case, Dr. Becker recounts, a doctor treating a 92-year-old patient for dementia billed for 72 comprehensive visits in two months. In another, a physician filed for 17 comprehensive visits in as many days for treatment of a single patient. Yet another doctor billed Medicare for seven emergency-room visits on the day his patient had a heart attack. "If they had been reimbursed, it would have been an outrageous expenditure of Medicare funds," Dr. Becker says.

Doctors concede there may be a few among them who make inappropriate claims, but they say the scrutiny is uncalled for. Moreover, they say, dealing with Aetna has been a bureaucratic disaster. And HealthCare Compare, they charge, is arbitrarily withholding payments to impress the HCFA in hopes of landing contracts if the review program expands. HealthCare Compare rejects the accusation.

Paul Shanor, executive director of the Medical Association of Georgia, also takes issue with statistics showing that doctors bill for too many comprehensive visits. And he questions the general fairness of the new procedure. One physician in Newnan, Ga., spent more than two hours in the middle of the night with a heart-attack victim, he says, only to be reimbursed $23 by Medicare. "That doesn't seem like a very fair amount to me," Mr. Shanor says.

Moreover, physicians say they have been made to feel like criminals and have been subjected to long delays in receiving legitimate payments. Take the case of Mary Sper, a 68-year-old who was hospitalized for six weeks late last year for gallbladder surgery. Because she had a history of heart trouble, her cardiologist, Wm. Michael Brown, visited her daily in the hospital. But it wasn't until August, after several appeals of payment denials and the submission of reams of documentation, that the cardiologist collected the $1,000 he sought from Medicare. "It was a headache on that one," says Mabel K. Kim, Dr. Brown's office manager.

Aetna does accept some blame. As a new Medicare administrator, the carrier faced a huge backlog of claims and admits mistakes in processing at the start. Aetna says the problems have largely been overcome, but only a few weeks ago a computer glitch resulted in erroneous underpayments for laboratory tests. The medical association calls the incident an example of Aetna's "bad faith."

The changes have shocked physicians, who had grown accustomed to certain givens in billing. Linton H. Bishop Jr., a cardiologist here, says he charged his "usual consulting fee of $117" to see a 73-year-old patient who was hospitalized for prostate surgery. The patient paid, but Medicare later said a comprehensive visit wasn't necessary and authorized payment of only $30. In this case, Dr. Bishop had to reimburse the patient the difference between the higher and lower fee.

Some doctors now protect themselves by forcing patients to sign waivers, making them responsible if Medicare denies payment. Exactly that happened to Grady Rutherford, a 75-year-old retired carpenter who had to fork over $85 for a "downcoded" visit to his internist. "I just feel like my Medicare insurance isn't doing justice one way or the other," a distressed Mr. Rutherford says.

Dr. Becker of HealthCare Compare dismisses the criticisms, saying his company is only ensuring that physicians aren't paid for unnecessary services. "Some of the people who have made some of the most noise are people who in fact are overutilizing and upcoding," he says.

Dr. Becker adds that it's going to get tougher for physicians before it gets easier. Starting in January, he says, scrutiny will be intensified for Georgia doctors who do tests and surgical procedures.

Meanwhile, the issue is spilling into politics. Responding to the medical lobby, Georgia congressmen persuaded Rep. Henry Waxman to examine the state's Medicare situation before his health and environment subcommittee. The inspector general of the Health and Human Services Department, the agency housing the HCFA, also is conducting a probe, as is the General Accounting Office.

But don't expect too much sympathy for Georgia's generally well-heeled physicians. Says Michael Cadger, managing consultant in Atlanta for A. Foster Higgins & Co., a benefits consultant: "Doctors are finally getting caught and they don't like it."

PETE V. DOMENICI
NEW MEXICO

United States Senate
WASHINGTON, DC 20510

COMMITTEES
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March 31, 1989

Mr. Don F. Seelinger, Chairman
Professional Review and Advocacy Committee
New Mexico Medical Society
303 San Mateo Blvd., N. E. Suite 204
Albuquerque, New Mexico 87108

Dear Don:

It is very encouraging to me to hear about your high marks for AETNA as the Medicare Carrier in New Mexico. I very much appreciate your support for this important relationship.

The improvements in timeliness of claims, accuracy of processing and an improved system of appeals all sound like vital aspects of a solid working relationship.

While I will continue to ask questions on behalf of any New Mexico doctor or constituent who asks, I have found no major problems to date.

It is also encouraging to know that you would like to see the New Mexico model of cooperation mandated throughout the country. As the Medicare issue and the related costs for the future become a more significant national issue, I am confident that we will be able to rely on your assistance to improve Medicare management throughout the country.

I thank you for your observations, and I look forward to hearing more about the aspects of the New Mexico model that will be fruitful for others to emulate.

Sincerely yours,

Pete V. Domenici
United States Senator

PVD:jt

NEW MEXICO
MEDICAL
SOCIETY

303 SAN MATEO BLVD., N.E., SUITE 204 ☐ ALBUQUERQUE, NEW MEXICO 87108 ☐ PHONE (505) 266-7868

November 7, 1988

The Honorable Pete Domenici
The United States Senate
Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Domenici:

I am writing you this letter as Chairman of the Professional Review and Advocacy Committee.

Our committee would like to commend AETNA which serves our Medicare Carrier and its manager Mr. Fred Bush for the cooperation we have received relative to medicare claims in New Mexico. Since AETNA has taken over as the fiscal intermediary for medicare, we have experienced a profound improvement in timeliness of claims, accuracy of processing and an improved system of appeals where problems of payment have arisen.

We have met on a monthly basis with Mr. Bush and those meetings have been open and very fruitful for our members. Since Mr. Bush and AETNA Medicare became our carrier, our society has commended Mr. Bush and indeed our committee for the improved relationship and the help provided to our members.

I know that you have received correspondance from Thomas Ramage, M.D., one of our excellent rheumotologists from Roswell, New Mexico. Dr. Ramage is concerned about our committee working with AETNA-Medicare on a cooperative basis. I can not speak to the merits of his claim regarding billing, charging and coding. We recently had a hearing with Dr. Ramage and he has a full recording of that meeting as do we.

I am writing you to explain that our committee believes AETNA-Medicare has behaved in an exemplary manner and our committee would further suggest that when you review the concerns raised by Dr. Ramage you first request additional input from other parties involved. Secondly, because we are so pleased with the function of the committee and with the medicare carrier's cooperation, we would suggest that this type of program be considered as a mandate from HCFA in other parts of the country. It would help to achieve the same high level of cooperation which has been so helpful in New Mexico.

If you have questions, or would like to have me appear at a hearing regarding any of these matters, I would be more than happy to do so.

Thank you for your courtesy in reading this letter and in giving thought to acting on our recommendation.

Sincerely,

Don F. Seelinger
Chairman

STATEMENT OF MARGARET DIENER

Ms. DIENER. Good afternoon.

On behalf of HealthCare COMPARE, I would like to thank you, Chairman Waxman and Dr. Rowland, for giving us the opportunity to testify before this subcommittee today. As Susan has said, my name is Margaret Diener and I am vice president of operations for HealthCare COMPARE. I am the person at COMPARE responsible for overseeing our Medicare subcontract in Georgia. As you requested, I have submitted a written statement for the record and will simply highlight that statement here.

HealthCare COMPARE has been performing a wide range of medical utilization review services since its founding in 1982. We are currently providing review for approximately 5 million covered lives in our non-Medicare business for clients who include insurance companies, third party administrators, self-insured employers and union groups. We welcome the opportunity to bring our proven medical cost-containment skills to this subcontract for Medicare in Georgia.

As you have just heard, the Inspector General has audited our policies, procedures and records and has found that we have done a good job. Through its subcontract with Aetna, COMPARE's job in Georgia is to provide medical and utilization review in accordance with Federal law. We are required to judge whether a particular medical service rendered by a physician to a Medicare beneficiary is medically necessary. This review is done by our staff of 48 in Savannah, including 22 nurses, a full time physician medical director and a physician consultant who is onsite in Savannah at least 3 days a week. In contrast, at the time Prudential withdrew from the Medicare program, it had only one full time nurse and a physician who worked 2 half days per week. Medical review was done almost entirely by nonmedical people.

COMPARE uses both prepayment and postpayment techniques to assess medical necessity. Prepayment review focuses on a specific service when it is rendered to beneficiaries, regardless of who provides the service. Postpayment review focuses on all services rendered by an individual provider to all of his beneficiaries over a period of time.

The Health Care Financing Administration requires COMPARE and all Medicare carriers to circulate proposed medical review policies to State medical societies for a 30-day comment period prior to implementation. Incidentally, this policy was put in place March 1 of this last year. COMPARE has gone beyond these requirements in seeking cooperation with Georgia physicians through extended comment periods and through numerous meetings.

We have met with physicians more than 50 times since January 1989. We have agreed to extend the comment period for all proposed policies from 30 to 45 days and in specific instances for much longer periods of time.

For example, we first published one proposed policy on August 22 of last year and did not finalize that policy until the end of November, after a number of letters and finally a meeting with the specialty society which was most affected by that particular policy.

As in our commercial business, medical review in Georgia has shown that unnecessary services are being rendered and billed to Medicare. According to Health Care Financing Administration, Georgia physicians have billed at the highest level of service, which is the comprehensive level, 23 percent more per 1,000 beneficiaries than the national rate. Our daily review supports this statistic.

For example, a 71-year-old patient with a blood stream infection was hospitalized. On October 2, 1989, a comprehensive initial hospital visit was billed. Then from October 3 to October 26, 24 more comprehensive visits were billed, one for each day of hospitalization. It is inconceivable that a complete physical examination, past medical history, family history and social history was performed or was needed for that same patient 25 days in a row, but that is precisely what the definition of a comprehensive visit it.

And even more extreme example was the case of a 92-year-old patient being treated for dementia. There were 94 comprehensive visits billed for this patient in a 9-week period.

Fortunately, not all examples are this extreme; however, this type of overutilization is costing the taxpayers millions of dollars. In the first 9 months of 1989, COMPARE's medical review in Georgia saved taxpayers $15 million. We did this by reviewing approximately 8 percent of all claims submitted in Georgia and we took action on less than 3 percent of all claims.

In conclusion, COMPARE is pleased to be part of the Medicare review process. Overutilization of medical services is a local, regional and national problem. Some estimates suggest that 10 percent or more of the annual $650 billion spent on health care is wasted on unnecessary care. Medical review can help solve this problem. This is the job that the Health Care Financing Administration has asked COMPARE to do. We are performing this job in accordance with Federal law and we are proud of our accomplishments. We have been audited and reviewed by the Health Care Financing Administration's regional office, by the central office and now most recently by the Inspector General. All have found that we are doing a good job in complying with the laws, rules and regulations.

Thank you for the opportunity to testify and I would be happy to answer any questions.

[Testimony resumes on p. 235.]

[The prepared statement of Ms. Diener follows:]

STATEMENT OF

HEALTHCARE COMPARE

ON

MEDICARE PART B

CARRIER TRANSITION

Good Afternoon. My name is Margaret Diener, Vice President of Operations for HealthCare COMPARE. On behalf of HealthCare COMPARE, I would like to thank you, Chairman Waxman, for inviting us to testify before you today. I am the person at COMPARE who is responsible for oversight of our Medicare subcontract in Georgia.

HealthCare COMPARE Corp. has been performing a wide range of medical utilization review services since its founding in 1982 by Robert Becker, M.D., our Chairman. COMPARE currently performs review for approximately five million covered lives. COMPARE's clients include group health insurance carriers, third party administrators, self-insured employers, government employee groups, multi-employer trusts, and Taft-Hartley Health and Welfare funds.

COMPARE believes that through the use of highly professional utilization management the costs of health care can be managed without compromising the quality of care. It believes that the attending physicians are the guardians of the quality of care for patients and that patients believe their physicians provide appropriate care. COMPARE provides professional utilization oversight for that care without affecting the relationship between attending physicians and their patients. At COMPARE, professionalism is attained through the use of medical personnel as reviewers. COMPARE believes that the quality of care is enhanced when the treatment plan for a patient is reviewed for medical necessity and appropriateness by an objective physician who has no financial, referral, or other relationship to the attending physician.

When the Ætna Life Insurance Company was chosen by the Health Care Financing Administration (HCFA) to replace The Prudential Insurance Company of America as the Medicare Part B carrier in Georgia effective January 1, 1989, Ætna selected COMPARE, a leading independent provider of health care utilization review services, as its medical review subcontractor. HealthCare COMPARE thus became the first independent medical review organization to provide federally mandated medical review/utilization review (MR/UR) for Medicare Part B through HCFA.

Medical review for Medicare Part B has historically been performed by an insurance carrier under contract with HCFA to administer such claims in each state (the Medicare Carrier). Although COMPARE has been granted some flexibility in administering the review process (for example, waiver of HCFA specified number of claims reviewed), it is still required to comply with all Medicare laws, rules, and regulations.

In order to provide the medical review for Medicare Part B, COMPARE chose to share office space with Ætna in Savannah, Georgia. We have a staff of approximately 48 individuals, including two physicians and 22 nurses in Savannah. Our Savannah staff is supported by the technical expertise for medical policy issues of COMPARE's Chicago staff which includes 27 physicians. We are also assisted

with analytic services provided by COMPARE's wholly-owned subsidiary, AFFORDABLE Health Care Concepts, which is based in Sacramento, California.

I would like to stress at this time that although COMPARE is a for-profit company, this Medicare subcontract is a cost-based contract. There is no profit to COMPARE from this contract. We agreed to provide this service on a non profit basis because we recognized that it was advantageous to us as a company to be involved in all sectors of medical review, including the government sector.

COMPARE'S Medical Review

Through its subcontract with Ætna, COMPARE's role in Georgia is to provide medical and utilization review. Section 1862 (A)(1) of Medicare law states "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which ... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." We are required to judge whether or not a particular service rendered by a physician to a Medicare beneficiary is reasonable and necessary in accordance with this law. COMPARE has no authority to decide how much is paid for a particular service.

Like any carrier which is performing medical review, COMPARE uses a combination of prepayment review and postpayment review for the purpose of assessing medical necessity.

Prepayment review techniques are focused on a specific service when it is rendered to a beneficiary. COMPARE will, for example, examine claims for a particular service, and review the frequency of the service or its relationship to the diagnosis on the claim. Selection (screening) criteria for identification of services for review are programmed into the claims processing, system. If, during claims processing a service meets programmed screening criteria, it is selected or "suspended" from routine processing and is then subjected to COMPARE's medical review. While the computer can select and identify services for review, it does not automatically deny or reduce payment for the suspended services. A claim is first reviewed by a trained claims analyst. More complex cases are reviewed by nurses and/or physicians. At the time Prudential withdrew from the Medicare program in Georgia, it had one full-time nurse and a physician who worked two half days per week; COMPARE has 22 full-time nurses, a full-time physician Medical Director, and a physician consultant on-site at least three days per week. During 1989, COMPARE suspended for review approximately 8% of all claims submitted to Ætna (Table 1).

Postpayment review techniques generally focus on review of all services an individual physician rendered to all of his Medicare beneficiaries over an extended period of time. HCFA requires us to prepare statistical analyses to identify

physicians whose practice patterns are statistically different from their peer group norms. An initial limited sample of patient records is reviewed, to determine whether a more extensive review is justified. If it is, a comprehensive medical audit is performed using full medical chart review by nurses and physicians. If unnecessary services are identified, appropriate remedies, as required by Federal law, are taken including recovery of overpayments, imposition of Medicare sanctions, referrals to the Inspector General, and ongoing prepayment review. In this type of prepayment review, all or selected services billed for by the physician may be subject to more extensive review.

Medical Policy Development

Ætna was awarded the Medicare contract in June of 1988. Like Ætna, COMPARE was faced with a very short time period to develop the necessary procedures and to hire and train staff to begin providing medical review on January 1, 1989. Our approach to prepayment review, therefore, was to evaluate what was then being done by Prudential in Georgia and by Ætna in its other states. In addition, it was necessary for us to learn the details of Ætna's claims processing system in order to provide detailed computer specifications for the selection of those claims which we wanted to review. Because of the short time frame, we decided to base our initial screens on those topics which had been mandated by HCFA for medical review nationwide.

The perspective that COMPARE brings to medical review is its recognition of continuity of patient care across place and type of service. Prudential's screens, for example, looked at repeat instances of the same type and place of service and compared the necessity of those repeat services only against themselves. COMPARE's approach recognizes that a patient/physician relationship exists across many places and types of service, and that it is appropriate to evaluate the services performed during an initial visit in the hospital, for example, against services which had been performed prior to hospitalization in an office or nursing home. We therefore made some modifications to the screens to accommodate that approach. It was our intent to supplement the modified mandatory screens with additional screens in April 1989 when the potential problems of backlogs and learning curves with new staff and new systems had been passed in the first months of 1989.

In March of 1989, HCFA imposed a new rule on all carriers for the development of medical policy. Essentially, the mandated process required not only advanced physician and provider notification of new policies but the opportunity for state medical and specialty societies to review proposed changes and comment on them prior to the formulation of the final policy. COMPARE welcomed this approach; indeed early in February 1989, it had convened a meeting to look at the definition of consultation. The new rule, however, substantially

increases the time necessary for policy development and we were therefore unable to add new screens in April as originally planned.

COMPARE has gone beyond the requirements of the regulation in seeking the input of physicians in Georgia. At the request of the Medical Association of Georgia, it has agreed to routinely extend its deadline for receipt of comments from 30 to 45 days. In addition, it has extended the deadline for even longer periods of time in some cases in order to allow specific specialty societies the full opportunity to review proposals. In addition, it has met with the urologists to review the proposed policy on transrectal ultrasound of the prostate and with a group of physicians twice to discuss the issue of consultations. It is COMPARE's intent to continue to seek active input into the policy development process by Georgia physicians. Nevertheless, COMPARE does have an obligation as a federal subcontractor to continue the development of policies and to respond to directives from HCFA on a timely basis.

Provider Relations

COMPARE has made a substantial effort over the last year and a half to meet with Georgia physicians and other providers and explain its methods for performing medical review. In August of 1988, we met with representatives of the Medical Association of Georgia to begin to develop a working relationship with that group. Between August and January 1, Dr. Korn and our Chairman, Dr. Becker, attended more than 15 meetings of state and county medical society groups. Since January, we have attended more than 50 additional local, regional, and national meetings.

In the early part of the year, Georgia physicians expressed concern that they did not have enough information about COMPARE's policies. In response to that, in April, we published "A Special Letter to Georgia Physicians" to explain many of the basic policies. Since then, COMPARE has participated with Ætna in publishing monthly, rather than the intended quarterly newsletters, to keep Georgia physicians abreast of activities. In May, we established a special number to allow physicians and their staff to call and talk to COMPARE directly about medical review issues, bypassing the general question number for Ætna. We are receiving approximately 275 calls per month on that line and believe that it has helped to answer many individual patient-specific questions for physicians and their staffs.

Review Results

What has been the result of COMPARE's review? COMPARE has reviewed approximately 8% of all claims submitted to Ætna prior to their being paid and has taken action on approximately one-third of those so that COMPARE is impacting less than 3% of all claims in Georgia. Numerous studies have pointed

to substantial over-utilization and upcoding in Medicare and health care as a whole. COMPARE makes no claims that we have resolved these problems in total, but believe that we have begun to address some of these issues. The fact that Medicare expenditures in Georgia rose more rapidly in fiscal year 1989 than they did for the nation as a whole or in this region (Table 2), suggests that managing health care costs remains a national challenge. During calendar year 1989, COMPARE review saved the taxpayers $17.6 million (Table 3). In many cases, the dollars saved resulted from the assignment of appropriate codes for the services rendered or for the non-payment for services which were not found to be medically necessary.

From the physicians' perspective, the most controversial action which COMPARE has taken has been the review of the comprehensive levels of service. As noted earlier, COMPARE recognized that the patient/physician relationship extended across place and time of service. Our decision to review comprehensive services was based on the mandatory HCFA screen for review of repeat instances of new patient office visits and on optional screens which Prudential used which looked at comprehensive initial hospital visit and comprehensive established patient office visit.

By way of background, the level of service for which a physician bills after an encounter with a patient is defined by an annual code book, the Current Procedural Terminology (CPT), which is developed under the auspices of the American Medical Association. HCFA requires that this coding system is used as the basis for Medicare reimbursement, but CPT is not a document or system developed by HCFA, Ætna, or HealthCare COMPARE. The CPT definition of a comprehensive service is as follows, and I quote:

> **"A level of service providing an in depth evaluation of a patient with a new or existing problem requiring the development or complete re-evaluation of medical data. This procedure includes the recording of a chief complaint or complaints and present illness, family history, past medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures."**

Contrary to media reports, it was never COMPARE's policy that there should only be one comprehensive service per patient/doctor relationship (once per lifetime) or for the claims' history. And I quote from COMPARE's "Special Letter to Georgia Physicians": "A comprehensive evaluation, inpatient or outpatient, by any physician is generally appropriate for an individual patient once during the patient's claim history and may also be appropriate for subsequent encounters for major medical problems generally related to previously unknown diagnoses." Given the above CPT definition, even a non-medical person can recognize that daily comprehensive evaluations are rarely performed and even more rarely necessary. But it is not uncommon to see a 15 day hospital confinement with 15 daily

comprehensive hospital visits billed to Medicare by a physician for one patient. This is not appropriate and is known as "upcoding."

In the first several months of 1989, it quickly became apparent that Georgia physicians disagreed with COMPARE's review of comprehensive levels of service. The Health Care Financing Administration therefore looked at the frequency of comprehensive services billed in Georgia compared to the rest of the country. Table 4 (attached) and the corresponding Figure 4 show that comprehensive services were billed 23% more per 1,000 beneficiaries in Georgia than the rest of the country. While that statistic does not of itself show that there is upcoding in Georgia, it certainly substantiates the need for careful review of comprehensive services. That difference is markedly greater for both initial and subsequent hospital visits and that information is provided in Tables 5 and 6.

It is also interesting to look at the total percentage of comprehensive services billed in Georgia which are being reviewed by COMPARE. Those tables by specialty are attached and show that approximately one out of five (20%) comprehensive services has been reviewed by COMPARE (Tables 7 and 8). Approximately 75% of the 20% suspended for review, or 16% of all comprehensive services billed in Georgia, have had a reduction in payment level by COMPARE (Table 9), based on the information provided to us. That reduction represents a reduction of approximately $24 per service for medical necessity and approximately $13 per service for other non-medical necessity issues such as reasonable charge or deductibles.

In addition to reviewing for comprehensive services, COMPARE has implemented the standard mandated concurrent care review screen and is also reviewing billing for initial consultations. As a number of physicians raised concerns about these topics, we convened a group of medical society leaders in November to discuss the topic of consultations. That group also discussed concurrent care and other hospital services. Based on that input, COMPARE has prepared revised policies for concurrent care, consultation, hospital visits, and critical care. Those proposed policies are currently being reviewed by HCFA and Ætna for compliance with regulation and will be released for review and comment by the medical community when HCFA and Ætna's reviews have been completed.

Since January when COMPARE began prepayment review with 13 general topics for review, we have added prepayment review screens for endoscopies, transrectal ultrasound of the prostate, and cardiac rehabilitation. We are working on policy statements for those areas of review suggested by HCFA including the administration of erythropoietin (Epogen), inpatient dialysis, TENS (transcutaneous electrical nerve stimulation), and have implemented a policy for review of seat-lift chairs and power operated vehicles. We welcome the input of Georgia physicians in the identification of areas of potential abuse and will work with them to develop appropriate screening mechanisms for those activities.

Transitions

As is well known to the individuals in this room, 1989 has been a difficult year for everyone in Georgia. COMPARE has had the opportunity to reflect on the experiences and would offer some suggestions for future transitions as follows:

1) Transitions should be longer than six months if at all possible, particularly when there is a complete start-up operation required. The short time frames required for the implementation in Georgia clearly had some negative impact on the transition.

2) It was probably a disservice to Georgia physicians to attempt to maintain the perception that the transition would be "transparent". HCFA should be the first to publicly recognize that there will be changes. COMPARE's statements that its policies would be based on the Prudential policies were unintentionally confusing to Georgia physicians who believed that meant there would be no change. It would be better, I believe, if all parties would recognize that there will be some change and work together to facilitate those changes rather than being unpleasantly surprised by them.

3) It would be appropriate for any incoming carrier and medical review organization to spend more time focusing on what the outgoing carrier was actually doing. COMPARE's focus was on learning Ætna's computer systems and how we would work with Ætna and insufficiently focused on understanding what Prudential did. Toward the end of the transition, we learned that we were unable to obtain the computer screening parameters used by Prudential for suspending claims for medical review and this created serious difficulties for us in understanding what Prudential had done. We learned that Prudential's system was so inherently different from Ætna's system that there was no one set of screening parameters which could be identified. While there is probably no way to require all carriers to use similar computer systems for suspending claims for review, it is imperative that thorough documentation of those parameters be maintained by a carrier even after many years in the Medicare program such as occurred with Prudential. Complete documentation was simply not available from Prudential despite sincere efforts on their part to make information available to us. The documentation simply could not be located. It would have been virtually impossible for COMPARE to exactly duplicate what Prudential had done, even had that been our intent, because of the differences in systems and the lack of documentation available from Prudential.

4) More emphasis should be placed on the orderly transfer from the outgoing carrier to the incoming carrier of non-systems data such as newsletters, procedure manuals, and so forth. This information can be as critical to a smooth transition as the systems data.

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5) Written communications concerning policy should be more frequent and detailed immediately prior to and after a transition. This would require an additional monetary commitment from HCFA. Face to face meetings are invaluable for developing an understanding of issues but should not be the forum for communicating policy issues. Meetings are useful for setting up communication networks and surfacing concerns.

6) The physician and provider communities need to recognize that changes in carriers will inevitably result in some changes in processing and work with the carriers to identify those areas. At the same time, this should not be an opportunity to blame the carriers for everything which they do not like about Medicare. Over the last year, we have found ourselves defending Medicare policy and trying to explain basic Medicare principles. We are pleased to explain Medicare policy, but there needs to be a recognition by physicians that neither COMPARE nor Ætna have the authority to change Medicare law. Rather that is the role reserved for Congress.

7) If possible, transitions should not occur on January 1 when the usual system demands are so substantial, given the January 1 implementation of new fee profiles, annual deductible calculations, and other congressionally mandated changes.

In conclusion, COMPARE is pleased to be a part of the Medicare review process. Overutilization of medical services is a national problem, not just a local one. Dr. Robert Brook of the Rand Corporation, who has been studying this issue, was recently quoted in the January 9, 1990 issue of Financial World as saying, "Almost every study that has seriously looked for overuse has found it, and virtually every time at least double-digit overuse has been found." The Financial World's article, authored by Lauren Chambliss and Sharon Reier, reported on the study by the bipartisan group headed by former Presidents Ford and Carter, and noted that approximately $650 billion are being wasted annually. This unnecessary care puts patients at serious risk. Medical review can and should eliminate some of this unnecessary care. This is the job HCFA has asked COMPARE to do.

We are performing our job in accordance with appropriate laws, rules, and regulations. Despite the media attention which has sometimes surrounded our efforts, we are proud of our accomplishments and are confident that the various audits and investigations currently underway will demonstrate that we are doing our job well.

Thank you for the opportunity to provide this testimony. We would be pleased to respond to any of your questions.

TABLE 1

COMPARE PRE-PAYMENT REVIEW

(Category II Screens)

1989

	Total Claims Entered	Claims Suspended	Percent Suspended
January	495,025	66,917	13.52%
February	659,354	67,484	10.23%
March	913,831	57,109	6.25%
April	779,432	54,321	6.97%
May	805,531	62,607	7.77%
June	838,376	70,059	8.36%
July	624,872	45,694	7.31%
August	832,563	63,663	7.65%
September	635,663	45,508	7.16%
October	846,899	56,334	6.65%
November	714,504	58,933	8.25%
December	724,555	51,700	7.14%
Annual Total	8,870,605	700,329	7.89%

SOURCE: AEtna 095 Report
Based on claims suspension date.

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TABLE 2

NATIONAL, REGIONAL, GEORGIA MEDICARE STATISTICS

	National	Region IV	Georgia
Total Benefits Paid			
1988	23,777,410,110	4,951,889,313	488,031,395
1989	26,533,003,484	5,592,814,555	559,253,079
% Increase	11.59%	12.94%	14.59%

SOURCE: Regional and National Interim Expenditure Report Statistics
From HCFA Region IV Office - Dated 12/08/89

TABLE 3

COMPARE PRE-PAYMENT REVIEW
(Category II Screens)

	# Services Suspended	$ Suspended	# Services Reduced or Denied	$ Reduced or Denied	% of Suspended Services Reduced/Denied	% of Suspended $ Reduced/Denied
Jan-March	330,101	$17,663,726	137,811	$5,279,798	41.75%	29.89%
April-June	407,790	$23,406,752	105,725	$3,986,149	25.93%	17.03%
July-Sept	459,115	$27,914,249	116,961	$4,420,710	25.48%	15.84%
Oct-Dec	430,972	$27,394,405	97,471	$3,902,502	22.62%	14.25%
Calendar Year Total	1,627,978	$96,379,132	457,968	$17,589,159	28.13%	18.25%

SOURCE: AEtna UR3020 Report
Based on claim paid date; does not include suspected duplicates.
Column titled "$ Reduced/Denied" is net of reversals EXCEPT for Jan-March.
and reasonable charge coinsurance reduction.

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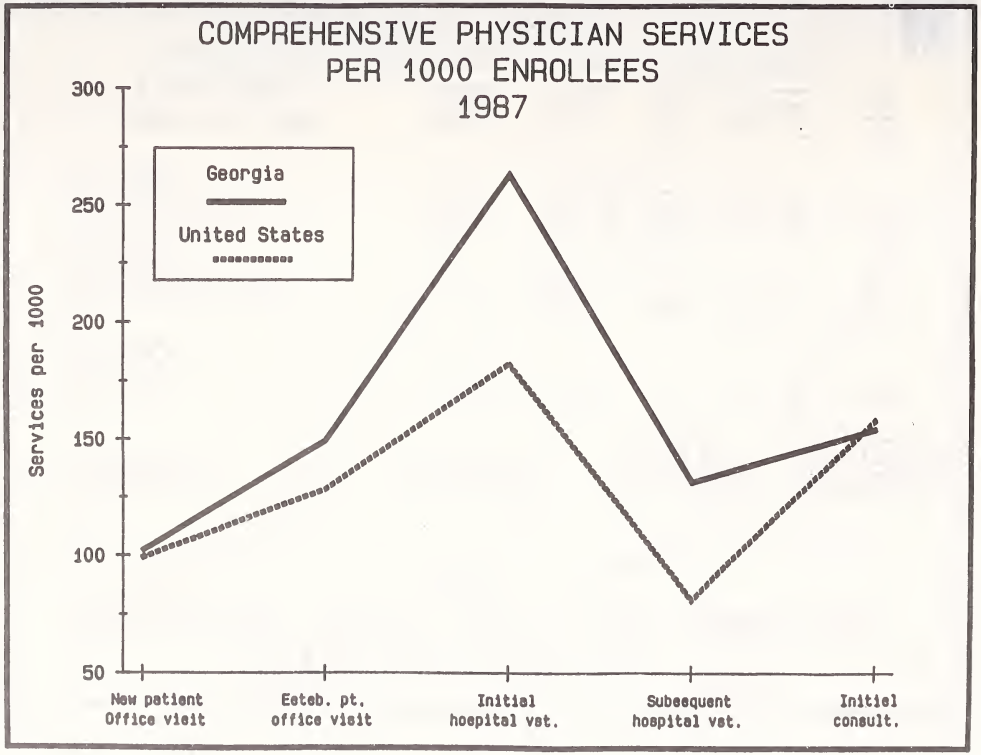
COMPREHENSIVE PHYSICIANS SERVICES PER 1000 ENROLLEES 1987

PROCEDURE	GEORGIA	UNITED STATES	VARIANCE
New patient office visit (90020)	102	99	+3
Established pt. office visit (90080)	149	128	+16
Initial hospital visit (90220)	263	182	+45
Subsequent hospital visit (90280)	131	81	+62
Initial consultation (90620)	154	158	-3
Total comprehensive services per 1000 enrollees	799	648	+23

Source: HCFA/BMAD

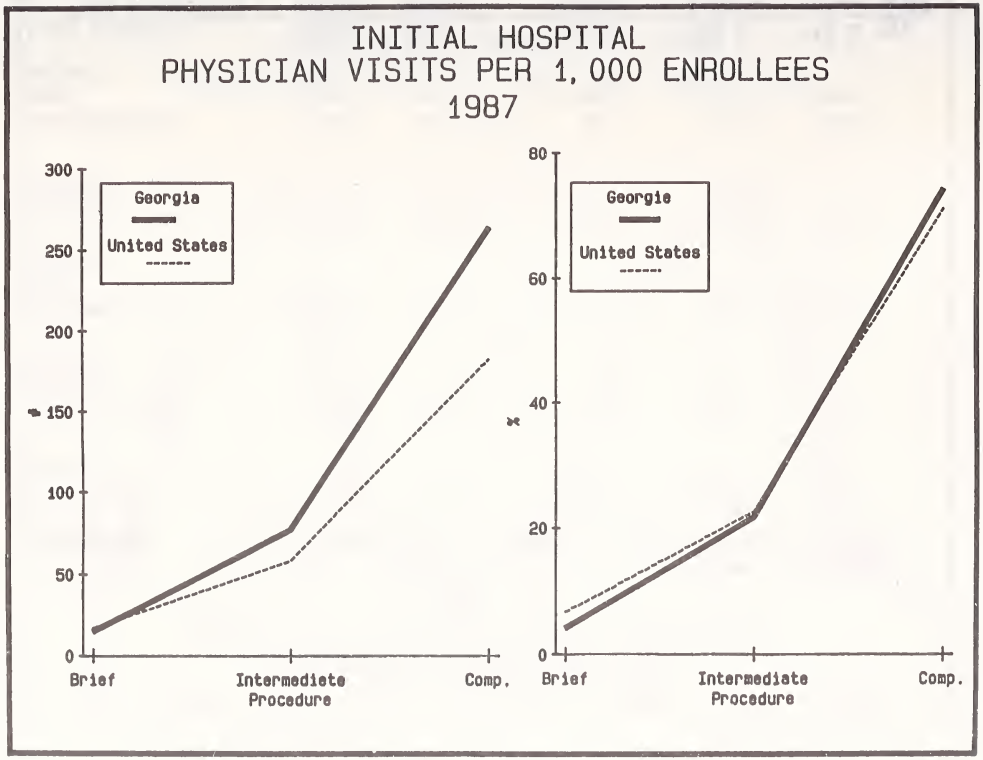
FIGURE 4


COMPREHENSIVE PHYSICIAN SERVICES
PER 1000 ENROLLEES
1987
Georgia
United States
Services per 1000
300
250
200
150
100
50
New patient Office visit
Estab. pt. office visit
Initial hospital vst.
Subsequent hospital vst.
Initial consult.

INITIAL HOSPITAL PHYSICIAN VISITS PER 1,000 ENROLLEES 1987

Procedure	Georgia	%	United States	%	Percent Variance
Brief (90200)	15	4.2	17	6.7	(12)
Intermediate (90215)	77	21.7	58	22.6	33
Comprehensive (90220)	263	74.1	182	70.9	45
TOTAL SERVICES PER 1,000 ENROLLEES	355	100.0	257	100.2	38

Source: HCFA/BMAD


INITIAL HOSPITAL
PHYSICIAN VISITS PER 1,000 ENROLLEES
1987
300
250
200
150
100
50
0
Georgia
United States
Brief
Intermediate Procedure
Comp.
80
60
40
20
0
Georgia
United States
Brief
Intermediate Procedure
Comp.

SUBSEQUENT HOSPITAL CARE
PHYSICIAN VISITS PER 1000 ENROLLEES
1987

PROCEDURE	GEORGIA	% of Total	UNITED STATES	% of Total	PERCENT VARIANCE
Brief visit (90240)	149	5.5	258	11.3	-42
Limited visit (90250)	923	34.2	756	33.2	+22
Intermediate visit (90260)	1175	43.6	957	42.1	+23
Extended visit (90270)	318	11.8	222	9.8	+43
Comprehensive visit (90280)	131	4.9	81	3.5	+62
Total visits per 1000 enrollees	2696	100.0	2274	99.9	+18.5

Source: HCFA/BMAD

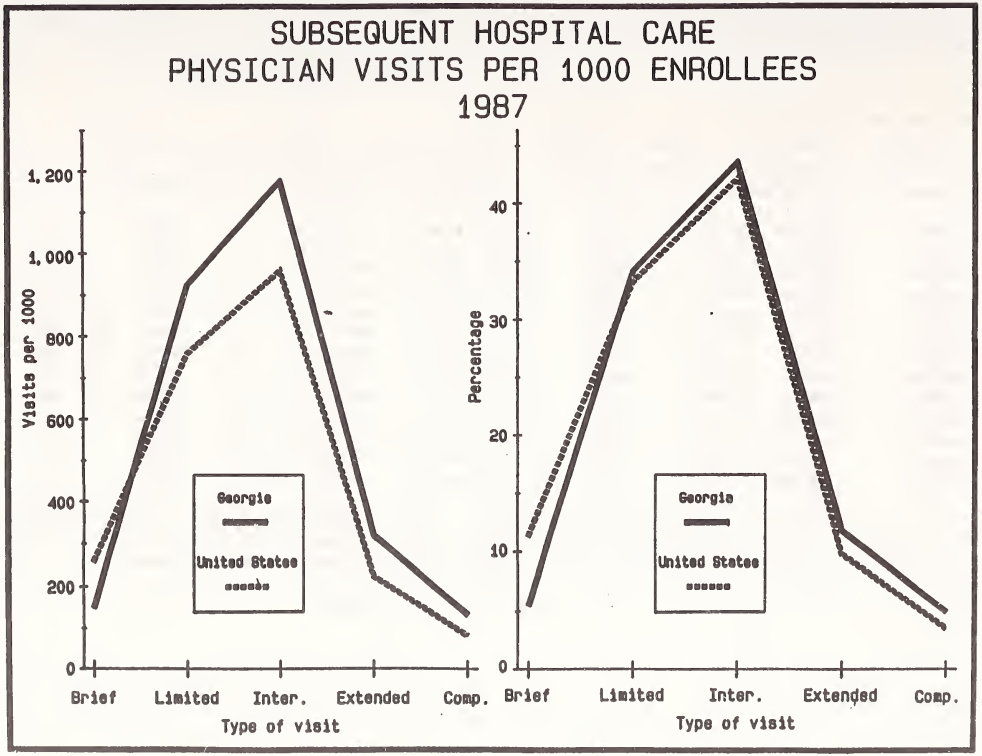

SUBSEQUENT HOSPITAL CARE
PHYSICIAN VISITS PER 1000 ENROLLEES
1987
Visits per 1000
1,200
1,000
800
600
400
200
0
Georgia
United States
Brief
Limited
Inter.
Extended
Comp.
Type of visit
Percentage
40
30
20
10
0
Georgia
United States
Brief
Limited
Inter.
Extended
Comp.
Type of visit

TABLE 7

REVIEW OF COMPREHENSIVE SERVICES BY SPECIALTY - JANUARY - JUNE, 1989

COMPREHENSIVE SERVICES BY ANALYSIS

NAME	CODE	CODE	SERVICES BILLED	DISTRIBUTION BILLED SERVICES	SERVICES SUSPENDED	% SERVICES SUSPENDED	SERVICES REDUCED	% SERVICES REDUCED	% SUSPENDED SERVICES REDUCED	DOLLARS REDUCED	AVER. REDUCTION PER SERVICE
Internal Medicine	11	11	143,194	42.1%	32,655	22.8%	26,816	18.7%	82.1%	$960,571	$35.82
General Practice	1	1	38,763	11.4%	9,913	25.6%	7,691	19.8%	77.6%	$223,101	$29.01
General Surgery	2	2	24,003	7.1%	5,066	21.1%	3,854	16.1%	76.1%	$134,105	$34.80
Cardiovascular	6	6	12,888	3.8%	2,986	23.2%	2,165	16.8%	72.5%	$72,938	$33.69
Neurology	13	13	12,751	3.7%	734	5.8%	480	3.8%	65.4%	$24,320	$50.67
Orthopedic Surgery	20	20	12,126	3.6%	1,687	13.9%	1,270	10.5%	75.3%	$37,444	$29.48
Urology	34	34	10,442	3.1%	1,800	17.2%	1,425	13.6%	79.2%	$40,068	$28.12
Ophthalmology	18	18	8,096	2.4%	807	10.0%	579	7.2%	71.7%	$20,151	$34.80
Psychiatry	26	26	7,863	2.3%	2,819	35.9%	2,374	30.2%	84.2%	$138,754	$58.45
Obstetrics/Gynecology	16	16	7,308	2.1%	1,091	14.9%	883	12.1%	80.9%	$26,310	$29.80
Thoracic Surgery	33	33	7,168	2.1%	1,660	23.2%	1,363	19.0%	82.1%	$39,508	$28.99
Family Practice	8	8	7,140	2.1%	1,565	21.9%	1,142	16.0%	73.0%	$28,007	$24.52
All Other			48,295	14.2%	7,269	15.1%	5,358	11.1%	73.7%	$200,228	$37.37
TOTAL			340,037	100.0%	70,052	20.6%	55,400	16.3%	79.1%	$1,945,505	$35.12

TABLE 8

REVIEW OF COMPREHENSIVE SERVICES BY SPECIALTY - JULY TO SEPTEMBER, 1989

COMPREHENSIVE SERVICES ANALYSIS

NAME	CODE	SERVICES BILLED	DISTRIBUTION OF BILLED SERVICES	SERVICES SUSPENDED	PERCENT SERVICES SUSPENDED	SERVICES REDUCED	PERCENT SERVICES REDUCED	% SUSPENDED SERVICES REDUCED	DOLLARS REDUCED	AVE. REDUCTION PER SERVICE REDUCED	AVE. REDUCTION PER SERVICE BILLED
Internal Medicine	11	40,130	27.0%	8,173	20.4%	6,278	15.6%	76.8%	$131,488	$20.94	$3.28
General Practice	1	14,247	7.5%	3,409	23.9%	2,632	18.5%	77.2%	$41,831	$15.89	$2.94
Cardiovascular	6	13,486	9.1%	3,146	23.3%	2,085	15.5%	66.3%	$44,559	$21.37	$3.30
General Surgery	2	11,082	7.5%	2,637	23.8%	1,871	16.9%	71.0%	$34,419	$18.40	$3.11
Family Practice	8	7,499	5.0%	2,063	27.5%	1,532	20.4%	74.3%	$22,469	$14.67	$3.00
Neurology	13	5,964	4.0%	425	7.1%	261	4.4%	61.4%	$5,564	$21.32	$0.93
OrthopedicSurgery	20	5,840	3.9%	979	16.8%	713	12.2%	72.8%	$9,472	$13.28	$1.62
Pulmonary Disease	29	5,420	3.6%	1,214	22.4%	993	18.3%	81.8%	$24,463	$24.64	$4.51
Gastroenterology	10	4,490	3.0%	731	16.3%	547	12.2%	74.8%	$13,091	$23.93	$2.92
Psychiatry	26	4,428	3.0%	2,135	48.2%	1,826	41.2%	85.5%	$49,611	$27.17	$11.20
Nephrology	39	4,233	2.8%	1,456	34.4%	1,157	27.3%	79.5%	$22,039	$19.05	$5.21
Urology	34	4,045	2.7%	740	18.3%	546	13.5%	73.8%	$6,952	$12.73	$1.72
Obstetrics/Gynecology	16	3,512	2.4%	607	17.3%	495	14.1%	81.5%	$9,735	$19.67	$2.77
Ophthalmology	18	3,226	2.2%	268	8.3%	183	5.7%	68.3%	$4,561	$24.92	$1.41
All Other		21,078	14.2%	3,782	17.9%	2,459	11.7%	65.0%	$53,224	$21.64	$2.53
TOTAL		148,680	100.0%	31,765	21.4%	23,578	15.9%	74.2%	$473,478	$20.08	$3.18

SOURCE: Special Data Extract

12/6/89

TABLE 9

COMPARE PRE-PAYMENT REVIEW
Claims Data 1989

Claims Processed by AEtna: 9,037,442

	# Claims Suspended	Percent of Total Claims Processed	# Services Suspended	$ Services Suspended	# Services Reduced/Denied	$ Reduced or Denied	Average $ Per Reduction/Denial	% # Suspended Reduced/Denied	% $ Suspended Reduced/Denied
COMPREHENSIVE	71,124	0.79%	134,538	$10,533,054	98,882	$2,347,375	$23.74	73.50%	22.29%
CONCURRENT	221,843	2.45%	555,747	$41,403,792	141,894	$8,825,841	$62.20	25.53%	21.32%
INITIAL CONSULTATION	63,442	0.70%	73,360	$7,260,261	22,919	$1,171,648	$51.12	31.24%	16.14%
Calendar Year Total	356,409	3.94%	763,645	$59,197,107	263,695	$12,344,864	$46.81	34.53%	20.85%

SOURCE: AEtna UR3020 Report
Based on claim paid data.
AEtna claims processed number from Line 11, 1565A

2/26/90

Mr. WAXMAN. Thank you very much for your testimony.

Ms. Stallings, can you tell us how the pilot project to use a private review firm came about and how in particular HealthCare COMPARE was selected for this project, what guidance did you receive from HCFA and were any other firms such as the Georgia PRO considered?

Ms. STALLINGS. The way the pilot came about was through direction of the Health Care Financing Administration. I think as George Holland testified earlier, it was an opportunity for HCFA to test the effectiveness of using an independent medical review firm versus the traditional process where the Medicare carrier employs staff to perform medical review, with a limited complement of medical professionals involved.

In examining which contractors or subcontractors Aetna would use, Bob Champagne primarily worked on that looking at various companies and their experience with medical review as well as their willingness to enter into the terms of the contract that we would have to initiate.

Mr. WAXMAN. Mr. Champagne, do you want to comment further?

Mr. CHAMPAGNE. Mr. Chairman, there was a very short duration from the time that the Prudential Insurance Co. indicated that they were leaving the program to the time of the award, so HCFA and any prospective contractor had to work very quickly on this. HCFA, in its definition to those who wanted to participate in the program, stipulated that at least for the Georgia contract, that it would be a requirement to have an outside firm do this. They made some suggestion as to the firms to be contacted.

I personally talked to about five different firms; CAPCARE, Signa, Aetna Insurance Co. itself and HealthCare COMPARE and probably one or two others. I had to make an evaluation on the basis of our oral conversations with them. I selected HealthCare COMPARE on the basis of their experience, even though there aren't many companies in this field who have long-term experience, HealthCare COMPARE had about 8 years experience at the time. They also agreed to participate in a cost reimbursement program. I was reluctant to get into any fixed price type of programs because this was new territory and I thought it would be easier to administrate on a cost-basis. They were willing to work with us in an integrated office in Savannah, which I felt was important because of work flows and so forth. They had many automated features, which some of the other companies did not have and also I found—experienced a feeling of cooperation with them. So I recommended to HCFA that they be awarded the subcontract.

Mr. WAXMAN. Can you tell us how your claims processing in Georgia differs from your Medicare contractor operations in other States? I am interested in any and all ways in which it might differ. I would also like to understand exactly how responsibilities are divided between you and HealthCare COMPARE.

Ms. STALLINGS. The primary difference, Mr. Chairman, is the HealthCare COMPARE end of it. We have pretty much all of the same positions in our Georgia Medicare office as we do in the other States that we service. As in any State, there are locality medical practice differences that come into play, but as far as the Medicare program, it is a Federal program and as far as the coverage and

reimbursement limitations that apply, they apply across the board, nationwide.

Aetna, in the seven States that we service, we are all on a common mainframe processing system, so that any changes that affect Georgia are also going to affect our other States. We do have an option file that allows us to put in things that are unique to Georgia, such as recognizing various procedure codes that are used in Georgia that may not be used in our other States, and things like that.

Mr. WAXMAN. And what criteria will you use to determine whether HealthCare COMPARE is doing a good job and should be continued?

Ms. STALLINGS. Aetna provides comment to COMPARE policy very early in the development stages. We also consult with them as far as new policies that they are proposing in terms of how it may impact the provider community and how it may impact our claims operation. We will depend primarily on HCFA's evaluation of the project as far as how it will be continued from here on.

Mr. WAXMAN. You do not make your own evaluation of HealthCare COMPARE that is acting on your behalf?

Ms. STALLINGS. We certainly, I would guess, will be asked for a recommendation as to how it is working and how it is blending in with our current operations.

Mr. WAXMAN. On what criteria will you give your suggestions to HCFA as to whether they are succeeding or not, what will be your criteria?

Ms. STALLINGS. I suppose, Mr. Chairman, that our criteria will be basically the same thing that HCFA's has been with the added caveats of the impact that it has had on our ability to meet Medicare standards that are required by the government.

Mr. WAXMAN. Ms. Diener, what is your understanding of the circumstances under which your firm was selected for this pilot project? Do you know whether any other firms or agencies were considered?

Ms. DIENER. I only have the information that Bob Champagne has already given you. I was the person at COMPARE who was involved in those discussions.

Mr. WAXMAN. What guidance do you receive from HCFA on how to develop medical review criteria?

Ms. DIENER. As I indicated to you before, there is a policy in which we must solicit input from the local physician community. In addition to that, there are directives given to our medical directors and guidance from HCFA's central office. We submit all proposed policies to HCFA and to Aetna for their review, prior to our releasing them for comment more generally, to make sure that they are in compliance with rules and regulations and so forth.

Mr. WAXMAN. How do you go about developing your medical review criteria generally? Have you been doing anything differently in this pilot project?

Ms. DIENER. Let me address how we developed the criteria for this pilot project. When we came to Georgia, the first thing we did was review what Prudential had been doing and what Aetna was doing in other States. There are a number of mandated screens that HCFA provides, that says you must look at these particular

topics. Under the pilot project, we were able to waive that mandate if we so choose. We felt, however, that it was appropriate to begin in the areas that HCFA had identified as problems nationally, and we went through a very detailed analysis of the activities in Prudential and in Aetna in each of their States. We waived one of the policies, we kept the others, modified them somewhat, and that was where we started.

We are looking now and working now on adding policies that are new mandates from HCFA in other areas which have surfaced as problem areas.

Mr. WAXMAN. Is this different from what you do in other States?

Ms. DIENER. We are not doing Medicare review in other States. We are doing review on the commercial side, and yes, there is some difference there.

Mr. WAXMAN. What is the difference?

Ms. DIENER. The major difference is that in our commercial business, most of our review is focused on hospital utilization, this is more out-patient utilization, so there's a different focus.

Mr. WAXMAN. What areas of discretion or latitude are you given under this pilot project that are not generally available to other Medicare contractors?

Ms. DIENER. As I said, we are able to waive some of the mandated screens. We also are not held to the same percentages, we can review a higher or lower percentage of claims.

Mr. WAXMAN. Do you review a higher or lower percentage of claims?

Ms. DIENER. We review a lower percentage at this time. We are able to use other techniques which are not in conflict with any existing laws, rules and regulations, which does not give us a lot of additional latitude, quite frankly.

Mr. WAXMAN. Your testimony notes that claims for comprehensive physician visits are submitted in greater frequency in Georgia than the national average. Do you have any information or any reason to believe that the patient population in Georgia is different than the national average and might warrant more extensive care?

Ms. DIENER. We have no ability to independently assess that information.

Mr. WAXMAN. Of the various complaints you have received from physicians regarding changes that have been made over the last year, can you sort out which are attributable to changes between your procedures and those of Prudential and which are attributable to new instructions from HCFA or changes in the Medicare statute?

Ms. DIENER. There are some of all of those, as you obviously understand. The concern I believe which has been expressed is not about changes we have made during the year, but the changes that we made when we came into Georgia in January. We quite frankly underestimated the level of that change. We, as I said, looked at the mandatory screens and modified them somewhat to try to take into account greater clinical sensitivity. We tried to understand Prudential's handling of claims and were only partially able to do that.

In my written testimony, I gave a number of recommendations for future transitions, and one of those was that much more atten-

tion be paid to what the outgoing carrier did and that further documentation be sought. We did try to get information from Prudential, but it simply was not available.

Mr. WAXMAN. So you really are not able to sort out the various complaints although they relate to all those issues.

Ms. DIENER. They really relate to all of those issues.

Mr. WAXMAN. Physicians have complained that even when an error in review policy is acknowledge, the change is only made prospectively. This forces the physician and patients to pursue individual appeals on previous claims. Is this an accurate statement of policy and if so, is it your policy or a directive from HCFA?

Ms. DIENER. It is not an accurate statement of our policy. I think the particular instance being discussed is when we changed the documentation requirements for a comprehensive visit. We did not set up practice parameters and I think our policies were misinterpreted to be practice parameters, so that we were decreasing the amount of documentation required in an effort to be responsive to concerns that had been raised. It was at HCFA's direction that there was no automatic reopening of old claims, but I would not agree with the statement that there were errors conceded either.

Mr. WAXMAN. Well if you found an error, would you correct it only prospectively as opposed to retroactively?

Ms. DIENER. If there is an error on an individual claim which surfaces either as a result of our internal audit or as a result of a review, we adjust it retroactively.

Mr. WAXMAN. Let me ask a question of both you and Ms. Stallings. How do you think the issues and problems we have discussed here are affecting the Medicare beneficiaries?

Ms. DIENER. We are not aware of beneficiary complaints. We have met with representatives from the American Association of Retired Persons, we are very concerned that what we do does not impact beneficiaries and we do not have any evidence that it is.

Ms. STALLINGS. I guess my perspective would be that there is certainly an impact to the beneficiaries when they receive the level or are exposed to the level of anxiety in their physician's office with regard to Medicare. The issue was raised as to whether the beneficiaries are isolated because of the high assignment rate in Georgia, and I do not think that they are because even with the high assignment rate, the beneficiaries are still responsible for the 20 percent co-pay and in some cases responsible for charges that are not covered under Medicare.

So I think enough of the anxiety has been passed on to them where they are very much familiar with the concerns in the physician community and I am sure they are very concerned about the availability of care and the availability of physicians that will continue to accept Medicare patients or Medicare assignment.

Mr. WAXMAN. Dr. Rowland.

Mr. ROWLAND. Let me pursue just a little bit the question that the Chairman was asking a few minutes ago. If you find that there is an error in a claim and it is a policy type of error, then you do not go back—you do not change the policy, you continue to address the problem on an individual claim basis. Did I understand that correctly or not?

Ms. DIENER. What I said I believe was that the particular policy in question, we changed the documentation requirements. In other words, what we were asking to look at in support of the need for the service. It is HCFA's policy that if there are errors, that they need to be appealed and handled through the appeals process. But if we were to be aware of an error, we would announce that.

Mr. ROWLAND. Have you found that to be the case and asked for changes?

Ms. DIENER. The example that probably comes the closest to that is the one about nursing homes which was raised earlier today. In the middle of February at a meeting here in Atlanta at the regional office, it was pointed out that there was a question about which had precedence, a State law requiring visits or something else. We immediately that day suspended review and subsequently modified our policies and never reinstated the more stringent policy, and that goes back to the middle of February.

Mr. ROWLAND. I want to ask both of you, Ms. Stallings and you, Ms. Diener, do you find that rules and regulations that you have to follow that come from HCFA are such that in cases they should be changed either administratively or by statute law, that you find it difficult to comply?

Ms. STALLINGS. Most of them are difficult to comply with because usually the time is very immediate. There would be some I guess in my personal opinion that I feel do not generate the benefits from the standpoint of the impact that it has on the beneficiaries, the providers and also the Medicare contractor. There are some things that we do that are pretty labor-intensive. Example, developing first claims for Medicare or secondary payer involvement. That is a very controversial issue when it comes to Medicare physicians and Medicare beneficiaries. They do not understand why do we have to hold up their claims until we get information about their working status and other insurance involvement.

Mr. ROWLAND. When you find a problem created by some policy, is HCFA responsive to you in changing that or dealing with that?

Ms. STALLINGS. Where HCFA, I would tend to say that they are, but in most cases, it is dictated by law.

Mr. ROWLAND. What you are saying then is that there needs to be some changes in statute law to address some of the problems that you encounter.

Ms. STALLINGS. Certainly that is the situation. Most of the adamant concerns that I have seen raised over the past say 6 months after we got the backlog in shape and things like that, have been program related issues. A very controversial one is the participation program and it is confusing for the beneficiaries as well as for the medical providers. But it is not something that HCFA can change, it is a statutory requirement.

Mr. ROWLAND. Have you discussed—has Aetna discussed this with HCFA?

Ms. STALLINGS. We discuss it in our regular monthly meetings and of course I think it comes up in most conversations when we are passing on information about inquiries and discontentment in the provider community.

Mr. ROWLAND. Are you aware of whether or not HCFA has made any effort to, if it did need to be changed by statute law, to move in that direction?

Ms. STALLINGS. I am not sure, but that would be a national issue. I would think that that is a concern that is coming not only from Georgia, but nationwide, with regard to that program.

Mr. ROWLAND. Do you think that is the type of thing that is responsible for some of the problems that we have had in the State of Georgia?

Ms. STALLINGS. I think so, based on some of the meetings that I have attended.

Mr. ROWLAND. Well let me repeat my question then. Are you aware as to whether or not HCFA has moved to try to change a statute law that might be causing a problem?

Ms. STALLINGS. I am not personally aware of it.

Mr. ROWLAND. In other words, you discuss this and talk about it, but then nothing happens?

Ms. STALLINGS. I would defer that question. I would not say that nothing happens, but I am not personally aware of what goes on beyond the regional office, in the central office, where really I guess the change in a law would have to be initiated.

Mr. ROWLAND. Let me ask you, Ms. Diener.

Ms. DIENER. I would basically agree with what Susan has said. I think that HCFA has been very responsive as we have surfaced issues that need some interpretation. We surfaced an issue with them sometime ago about consultation and the latest directive that came out from the central office clarified that issue to our satisfaction. Nevertheless, it is clear that a number of concerns expressed by physicians really are statutory kinds of concerns. Probably the one that we find the most difficult is lack of understanding that Medicare does not pay for routine screening activities of a variety of kinds. So we often get into discussions of things and people say well it is good medical care and we say but it is not covered by Medicare, there is nothing that we can do about that.

Mr. ROWLAND. Well apparently this is a problem of not communicating very well, do you think—or not?

Ms. DIENER. Obviously we have not been completely successful in communications. We would not be here today if it were otherwise.

Mr. ROWLAND. I will amen that.

Ms. DIENER. But at the same time, Medicare is incredibly complex, the Medicare carrier's manual is very thick, it takes a long time to understand the details and the ramifications of what is and is not allowed, and I do not know that any person who is not working in the system could ever really be an expert in all the pieces of it.

Mr. CHAMPAGNE. Dr. Rowland, if I could amplify on that.

Mr. ROWLAND. Mr. Champagne.

Mr. CHAMPAGNE. You recall the meetings we had in Savannah with the physicians and Congressman Lindsay Thomas indicated earlier today a stack 2 feet high was passed to us. We have reviewed those documents and we prepared a separate letter for him identifying those items in there that were legislatively impacted. I will be happy to submit for the committee a copy of that letter.

[The letter referred to follows:]

Ætna

Employee Benefits Division
Medicare Administration
151 Farmington Avenue
Hartford, CT 06156

Robert S. Champagne
Director
Medicare Administration
(203) 636-5669

Medicare

May 2, 1989

The Honorable Lindsay Thomas
431 Cannon House Office Building
Washington, D.C. 20515

Congressman Thomas:

Ætna has responded to all of the statements/letters submitted to you at the March 28 Savannah meeting of the Georgia Medical Society. Copies of these responses were sent to you last month.

You asked at the meeting that I identify those issues that were based in law or regulation. I have done so.

Issue:

Ætna or HealthCare COMPARE do not allow payment for services beyond what the diagnosis or medical practice deems necessary. This includes evaluation of concurrent care, consultation by the same specialty, upcoding of follow-up visits to initial visits and/or established patient visits to new patient visits.

Section 1862 of Title XVIII of the Social Security Act stipulates:

> notwithstanding any other provisions of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services...which are not reasonable and necessary for the diagnosis or treatment of illness or injury...

A number of HCFA guidelines further define carrier responsibilities.

Issue:

Laboratory fees are being denied on the basis that the laboratory is not certified to perform the tests.

Section 1861 of Title XVIII of the Social Security Act provides that:

> No diagnostic tests (will be covered if) performed in any laboratory which is independent of a physician's office or a hospital...unless such laboratory...is approved by the State.

Issue:

Time increments for the payment of anesthesiology benefits.

Section 405.553 of the Code of Federal Regulations states that "the carrier will allow for no more than one time unit for each 15 minute interval...

Issue:

Beneficiaries are told that their physician did not accept assignment and they should write or call for the name of a participating physician.

The Omnibus Budget Reconciliation Act of 1986 and The Committee Report of The House of Representatives indicates that "carriers would also be required to develop and implement programs to familiarize beneficiaries with the participating physician program and assist them in using the program to select physicians."

Issue:

The goal of Ætna (and other organizations) is to save money on health care expenditures.

Under Title XVIII carriers are reimbursed only for the cost of administering the program. No monetary benefit enures to Ætna for reductions made to physician payment reductions.

Issue:

Unassigned claims billed without a diagnosis code will make the provider liable to fines and penalties.

Section 202G of the Catastrophic Coverage Act of 1988 provides civil monetary penalties if the physician knowingly and willfully fails to provide the code.

Thank you for allowing us the time to meet with you and the Georgia delegation. I hope the above provides you with sufficient information to determine the congressional mandate of certain program initiatives. I have not utilized legal counsel to explore and amplify these, my intent was to simply provide you with a general background. If you want me to pursue this further,or discuss this with you in detail, I will be pleased to do so.

I am distributing this to those that specifically asked for a copy at either the Savannah or Washington meetings.

/jhw

c: Kathy Bryant Hennemuth, Legislative Assistant
Frank E. Carlton, M.D., President, Georgia Medical Society
George Holland, Regional Administrator, Atlanta RO

Mr. ROWLAND. That will be fine.

Ms. Stallings, are you satisfied with HealthCare COMPARE and the work that they are doing now?

Ms. STALLINGS. Yes, and my confirmation comes from the fact that we have been reviewed by several entities and most recently being looked at, compared to a totally different and outside independent review involving the Office of Inspector General. As I said earlier, I think we, as a Medicare contractor, and having been in the program as long as we have, we recognize that there is a need for some medical review and appropriateness of services consideration in what we do. You know, we are constantly concerned about the Medicare budgeting process and the fact that the pocketbook gets very limited from year to year with regard to the funding that goes to the contractors, and we know that this is certainly driven by the expenditures of benefits that go out every year.

Mr. ROWLAND. Ms. Diener, obviously you think something must have gone wrong or else we would not be here, as you say. What did go wrong, in your opinion?

Ms. DIENER. I think there were a number of things which made this a very difficult transition. We have talked about the difficulty, Susan has, of going in a very short time period. There was the difficulty of doing this transition on January 1 when there are a lot of other things that happen in Medicare. As I said, we underestimated the level of change and did not—we were not trying to hide anything from Georgia physicians, we simply did not anticipate how much the things had changed compared to what we thought we were changing. And unfortunately much of that seems to have carried over and we are working out of a situation where there is a lot of lack of understanding.

Mr. ROWLAND. What are you going to do about that?

Ms. DIENER. We are trying to do many different things. We established back in May, a direct number, bypassing Aetna's general review number, to allow physicians to call in and talk with us about individual questions. We are getting about 275 calls a month on that line and that has not changed over time, that seems to be about what we are going to get. With Aetna, we have started publishing monthly rather than quarterly newsletters, which was initially intended. We are participating in meetings monthly. We are continuing to try to work with physicians on specific policies, either in groups or individually. We have added a panel of Georgia physicians to help us as consultants on specific activities. And we are going to continue to try to communicate as best we can with all of the various groups.

Mr. ROWLAND. I have one other question, Mr. Chairman.

We had an office manager when I was in practice who came in some day and said you are not getting enough bad checks backs. I said what do you mean and she said well you are not really putting enough pressure on people to pay, you need to put more pressure on them, you need to be getting more bad checks.

Let me ask you this. Do you disallow a certain percentage of claims to be sure that you are putting enough pressure on?

Ms. DIENER. No, absolutely not.

Mr. ROWLAND. Well then are you not afraid you might be letting some go through that ought not to go through, if you are not doing that?

Ms. DIENER. I am sure that there are claims that could be denied that we are not denying. I think it is interesting that the biggest area of difference that OIG found with their medical consultant is that most of the time when they disagreed with us, they said that we were being too lenient, that they would have been more stringent. But we do not have a predetermined percentage, we look at each claim based on policies and the evidence that is submitted, and make a judgment on that. We are not making a preset percentage.

Mr. ROWLAND. Mr. Chairman, I know that you have got to leave, you have got a plane to catch, but let me just make one comment here. I really appreciate everybody coming today.

I still have a feeling of great uneasiness about what is going on in our State. I believe that unless this is in some way corrected, and we would get at some of the base causes of the problem that we are experiencing—we are going to see a lot more than 150 physicians in the State of Georgia withdraw from the Medicare program, based on what I hear in talking with physicians. And I certainly have not had a scientific poll, it is just a feeling that I have.

So I want to urge everyone to move as expeditiously as you can to address this problem and not wait until the horse leaves the barn to do it, because I think that not only is it going to affect the State of Georgia, it is going to affect the Medicare system throughout the entire country.

Mr. Chairman, I thank you again so very much for being here.

Mr. WAXMAN. Thank you, Dr. Rowland.

Let me just ask a couple of other questions that came to my mind.

Dr. Copeland testified earlier and he said that in August 1989, HealthCare COMPARE agreed that their existing standard was in error, provided a draft of a revised comprehensive service documentation requirement. Is that an inaccurate statement, Ms. Diener? You said there were never any acknowledgments of a policy that was inaccurate.

Ms. DIENER. We said that our policy and our documentation requirements were putting a paperwork burden on Georgia physicians as well as frankly on us and on Aetna and that we were correcting that. We did not say—and the other statement that Dr. Copeland made is that we had said that we only allowed one comprehensive visit per lifetime. That was never our policy and we did not change that policy because that was not our policy.

Mr. WAXMAN. I am not sure that I am going to repeat the example that he gave exactly the way he presented it to us or in fact took place but as I recall his testimony from earlier in this hearing, he indicated a patient came in with an emergency problem, he had to do a workup on that patient, refer the patient to another physician, who was a surgeon, to deal with the problem. The claims were submitted, his was denied because one, there had already—I guess the patient had already been his and he had seen the patient before, and two, his was denied as I recall he said because another

physician was dealing with this patient, presumably the surgeon, and he was told that in effect he volunteered his time.

Does that sound right to you, if those were the circumstances?

Ms. DIENER. I can guess what may have happened with that claim. Concurrent care basically says that two physicians should not provide the same service for the same diagnosis. We find that sometimes when there are situations like that appealed, we get additional information that shows us that the physician was treating something else or there was a different service needed. Without having the specific claim, I would not be able to comment on it.

Mr. WAXMAN. Let us say there was that kind of misunderstanding. I presume it is a misunderstanding. A claim is submitted and HealthCare COMPARE looks at it and says in effect well this looks like a doctor putting in a claim for something else that was already done by another physician concurrently, we are only going to pay one, so therefore, I assume you are going to pay the one that comes in first. What is the doctor who submits his claim second in time supposed to do? Resubmit the claim, come in with extenuating circumstances?

Ms. DIENER. He can file a request for a review and provide additional information and we will then review it based on that.

Mr. WAXMAN. What does that mean as a practical matter, when he wants a review. What does he have to file, how much does he have to file? Does he have to personally appear? Give me some idea of what that means as a practicality.

Ms. STALLINGS. I will respond to that. The appeals process is outlined in the Medicare carrier's manual and I am sure in the law. The Medicare claimant has the right to write a written discontentment letter to Aetna, as the Medicare contractor, stating their displeasure with the original determination. At that time, if they do have evidence that will help support the services, then that should be submitted as well. That may be in the case of concurrent care, an indication of a separate diagnosis, I was seeing the patient for this condition and not for the same condition that Dr. *X* was seeing the patient for. If the appeals process, the first level review, determines that the original decision was correct, then the next level of appeal is a fair hearing. And I think Dr. Copeland was referring to the process where the hearing requirement says that there must be at least $100 in controversy in order to appeal at a fair hearing level. In that particular case, the doctor or the claimant would have the availability to appear in person, have a telephone hearing or a hearing on the record, and they make that decision and that choice.

Mr. WAXMAN. Do you know how many reversals there are based on that first level of explanation by a physician?

Ms. STALLINGS. Early last year, I would say probably through November or October last year, our reversal rate was above 50 percent. Right now I do not really know what the exact numbers are, but I would hope that it is less because we are making less errors.

Mr. WAXMAN. Do you know how many of those reversal rates were for claims of less than $100?

Ms. STALLINGS. I sure do not, I do not have that number.

Mr. WAXMAN. I would like that information.

Ms. STALLINGS. All right.

Mr. WAXMAN. I am wondering whether there is any validity to the claim that perhaps if it is under $100 it is routinely turned down and the doctor is told if you want to spend the time and effort to go after less than $100, go ahead and do it; therefore, as a practical matter keeping them from getting compensated.

Ms. STALLINGS. Well the way it is set up, Mr. Chairman, it allows the provider to accumulate enough claims to meet that $100 stipulation. So it does not prevent him from, say for instance, if he is seeing a pattern of denials, to accumulate several claims and come up to meet that requirement.

Mr. WAXMAN. Well I guess the reality that we have is in order to protect the taxpayers' money, we ask the fiscal intermediaries and those that work for them to try to screen claims to be sure that they are legitimate and justified, and that has to mean bureaucracy which can at times be in error, and it has got to be very frustrating for a physician to be told that what he thinks is being done in the best interest of his client, is something that is not recognized as legitimate by the Medicare program, sometimes the error is on one side or the other or both.

I would be interested, although I know that these suggestions get passed on through the different levels, if you see some problems along these lines that are based on the statute, you feel free to let Dr. Rowland or me know directly and not have to feel that you must go through the regional, national, et cetera. I think that might help us to deal with the problem on a national basis.

To the extent that the problem is poorly worded or improper statute, if we do not hear from anybody about it, we do not know to change it. Sometimes we hear about it and want to change it and still get frustrated. But we would like to at least try to give it a try to make this whole thing rational.

Dr. Rowland.

Mr. ROWLAND. Let me just ask to be sure that I understand this. I am going to give you a for instance, for instance I am a family physician and I have a patient that comes in that has got an abdominal problem. I work the patient up and I find out that they have got a leaking aneurysm, we call in a vascular surgeon. The vascular surgeon comes in, does the operation, the patient goes bad, we have to call in a nephrologist because his kidneys are not functioning. Then some other problems with his heart, we have to call in a cardiologist. Are you saying now that only one person is going to be paid out of that?

Tell me what takes place there.

Ms. STALLINGS. What we try to educate the physician to understand is for each of those physicians attending that patient, they need to provide us the condition for which they were treating the patient. Do not give us the admitting condition that got the patient in the hospital. The nephrologist should give us something to support the need for a nephrology specialist seeing the patient, the kidney failure situation. The cardiologist, the same, and so forth and so on. We are not saying that concurrent care is not covered at all. We are saying that legitimate concurrent care is covered, provided the documentation is presented with the claim.

Mr. ROWLAND. Let me pose this question for you. You have an admitting diagnosis as a family physician and you do not feel you

are competent, you want some help with that, and you call in an internist to help with it. The diagnosis is the same.

Ms. STALLINGS. Okay, in that particular case, I would guess that would be billed as a consultation and they would both not bill for an admission to the hospital. That usually turns out to getting one or the other claims denied, when they both bill for an admission to the hospital or initial hospital examination, rather than billing for a consultation opinion.

Mr. ROWLAND. You would be paid differently then if it were an admitting diagnosis vis-a-vis a consultation diagnosis, or a consultation?

Ms. STALLINGS. Well we are not paying on the basis of the diagnosis in this case. We would be paying on the basis of the service that was rendered. The family physician would have admitted the patient with the same diagnosis that the consultation was called in—the consultant was called in for. So the family physician would be billing for a hospital admit or initial hospital visit or emergency room care. The consultant would be billing for a consultation, and that is no problem if those diagnoses are the same.

Mr. ROWLAND. I really am interested in the number of 50 percent that you said were denied concurrent on submission of claims earlier, and you do not really know what it is right now?

Ms. STALLINGS. What I said was 50 percent of the reviews that we handled through probably the end of October turned out being that the additional payment was made or the original determination was reversed. I am not sure, but we will submit that for the record, what it is at this current time.

Mr. WAXMAN. I want to thank you very much for your testimony. We will look forward to reviewing this matter further and I want to thank Dr. Rowland for bringing this whole issue to our subcommittee's attention. This is obviously a big problem here in Georgia, but it does have national implications as we look at the Medicare program as it exists today and as we move into some of the changes that are contemplated by virtue of the law adopted at the end of last year, which Dr. Rowland had a great deal to do with, to change the way the physicians are going to be reimbursed. It is going to be an undermining of the Medicare program if physicians are treated unfairly and their patients' claims denied. I think it is something that we have to watch very, very carefully, make sure that we are paying only for what is appropriate, but that it is all being done in a way that is fair to everybody involved. If it is not fair to everybody involved, then it seems to me that we are going to have a continuing problem and a worsening problem, which could end up denying the patients that we promised health care to, access to good quality care. That would be a very, very bad result indeed and one that none of us would like to see occur.

I want to thank everybody for participating in today's hearings. We will leave the record open to receive additional statements that people have requested the opportunity to submit for the record. And we will share this whole record with our colleagues as we review the Medicare program in this year's reconciliation and beyond. Thank you all very much. That concludes our meeting.

[Whereupon, at 4:10 p.m., the hearing was adjourned.]

[The following material was submitted:]

Ætna

Employee Benefits Division
Medicare Administration
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

Medicare

June 1, 1990

Peter Bouxsein, Counsel
Health and Environment Subcommittee
2415 Rayburn House Office Building
Washington, DC 20515

I am enclosing two items that were requested at the March 5 Hearing in Atlanta.

The first is to the letter sent to Congressman Lindsay Thomas identifying certain Medicare controls that were based upon law and regulation.

The second concerns information on appeals reversal rate and hearings under $100. This information follows.

APPEAL ACTIVITY - 1989

All claims, where the beneficiary or provider of services on assigned claims expresses dissatisfaction with the claim adjudication, are reviewed regardless of the dollar amount. Results for 1989 are as follows:

Month	Completed	Withdrawals	Affirmed	Reversal part/full	% Rate Reversed
Jan-Mar	6,381	159	1,913	4,309	69.2%
Apr-Jun	13,853	685	4,302	8,866	64.8%
Jul-Sept	37,240	265	14,042	22,933	62.0%
Oct-Dec	61,838	972	20,972	39,894	65.7%

Note on above data:

- Numbers reflect all appeals not just Medical Review appeals.
- National reversal rate appeals is approximately 60%.
- Additional information being submitted with the appeal request.

Peter Bouxsein
June 1, 1990
Page 2

Hearings

By law, hearings must involve amounts of $100 or more. During 1989, in Georgia, only 42 hearings were dismissed because of the $100 limitation.

For hearings conducted in 1989, statistics follow:

Month	Completed	Withdrawals	Affirmed	Reversal part/full	% Rate Reversed
Jan-Mar	202	20	117	65	35.7%
Apr-Jun	196	25	83	88	51.5%
Jul-Sept	115	41	19	55	74.3%
Oct-Dec	121	64	15	42	73.6%

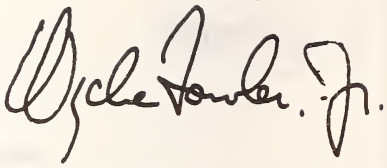
Note on above data:
National reversal rate on hearings is approximately 60%.

If additional information is required, please let me know.

Sincerely,

R. S. Champagne
Assistant Vice President
Medicare Administration

nr



Senator Wyche Fowler, Jr.
Medicare hearing
March 5, 1990

I am very pleased that Congressman Rowland has convened this hearing today. We must continue to address the serious Medicare problems in Georgia.

When the Medicare program was established 25 years ago, it was intended to ensure that the elderly receive affordable, quality health care. Over the last two and one half decades, beneficiaries, health care providers, and program administrators have worked together to make the Medicare system a success. Essential to continued success is a relationship of trust between the participants in the program. Beneficiaries must have confidence that they will be able to receive necessary care through Medicare and have their claims processed, and health care providers must be certain that they will be accurately reimbursed. Over the last year, the situation in Georgia has put this trust in jeopardy.

Every transition process involves problems, especially in a complex, expansive program like Medicare. The extensive problems resulting from the Medicare carrier transition process in Georgia, however, have exceeded the customary level.

We have seen cases where it has taken several months to process a beneficiary's claim. Beneficiaries have been reimbursed at inequitably low amounts. There have even been extreme cases where the beneficiary received a check amounting to less than one dollar. Physicians and other health care providers have had reimbursement for treatments and procedures unfairly denied, causing too many of these providers to stop participating in Medicare.

Many of these problems have been addressed over the last year, and the overall situation has gradually improved. Some problems remain, however, and we must continue to address them. We also must look at this situation and see how our experience can help other states avoid some of the same problems.

The provision of health care under Medicare involves a great deal of trust between beneficiaries, providers, and program administrators. Throughout our state, this trust has been violated. We must ensure that there are enough doctors and other health care providers participating in Medicare that beneficiaries can receive quality care, and we must make certain that these beneficiaries are able to have their claims processed in an accurate and timely manner.

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine appreciates this opportunity to share with the subcommittee its views on the administration of Part B of the Medicare program. ASIM represents over 20,000 practicing internists who, as primary care physicians, see a large portion of Medicare patients in their caseloads. Consequently, these internists are intimately familiar and directly affected when things go wrong with the Part B claims processing system.

We commend the subcommittee for its interest in the problems that occurred in Georgia with the Medicare carrier, Aetna, and its utilization review subcontractor, HealthCare COMPARE. We also appreciate the subcommittee's willingness to use the information it gains from the situation there for a broader assessment of Part B administrative problems nationwide.

ASIM is on record in support of Medicare demonstration projects to test the feasibility of using private review firms and methodologies as part of a comprehensive strategy to control the volume of ineffective services. Unfortunately, the manner in which Aetna and HealthCare COMPARE implemented this program in Georgia have the potential of jeopardizing the support of the physician community for any future efforts to use private review firms in the Medicare program.

As has been pointed out in other testimony, despite HCFA directives to the contrary, lack of communication between Aetna and physicians was a major contributing factor to the severe problems that eventually arose in Georgia. In addition, what few steps Aetna took to meet with physicians in that state were largely limited to updating physicians about new requirements. Little effort was made by the carrier to work with physicians in formulating the policy behind the new utilization review requirements. As ASIM wrote

in a letter to HCFA about the problems with the Georgia carrier, "experience in all fields shows that change is successfully accomplished when all involved parties have input to the change process. It is our experience that those carriers that have worked with the medical community in the development of realistic and credible medical review programs have been far more effective in controlling the volume of ineffective services than those that have discouraged such involvement."

ASIM is pleased that a dialogue has begun between the parties involved in the Georgia controversy and expects that the interest expressed by the subcommittee will be a positive influence in efforts to resolve the situation. However, ASIM would like to draw the subcommittee's attention to the fact that the difficulties experienced in Georgia are not an isolated case but merely illustrate what is happening to physicians around the country when confronting payment and review problems with the Medicare program.

ASIM believes that the issue of reducing the administrative burdens placed on physicians by the Medicare program should be on the Congressional agenda for ongoing consideration. Although not exclusively payment-related, many of the administrative burdens imposed on physicians have come about as part of efforts to reform the payment system. Many more such requirements may come about as a result of implementation of the new payment system or as a result of future Congressional mandates. The requirements that physicians file all Part B claims for beneficiaries beginning in September and use particular diagnostic codes in their bills to Medicare are just two examples of administrative requirements that Congress assigned to physicians in recent legislation.

Judging from the letters, phone calls and resolutions from ASIM members, the administrative burdens--or hassles--associated with the Medicare program and other

payors are now the biggest concern of internists, even exceeding concern over inequitable payment. Physicians are tired of review programs that require them to justify every decision they make on behalf of their patients, but that seem incapable of disciplining those physicians who are truly abusing the program. They are tired of having to go through multiple appeals in order to get paid for their services. This can be particularly frustrating when a physician wins the reversal of a payment denial but realizes there will be no long-term effect since the next claim for the same service, on the same patient, with the same diagnosis, will still be denied. Physicians are concerned with the program's seeming indifference or hostility to professional input. They are angry about a never-ending deluge of new requirements--some well-intentioned, many not--that have no relationship to the way medicine is really practiced, or that are extremely costly or difficult to comply with.

Numerous examples exist of rules instituted by HCFA or interpreted by carriers in such a manner that require additional attention from the physician that would ordinarily be given to patient care. Many services that are obviously medically necessary are identified by carrier "screens" and frequently denied, downcoded for lower reimbursement or held for further documentation. The additional paperwork and time spent by physicians and their staffs in trying to get through to the carrier by phone causes a great deal of resentment in the medical community.

Other services may be deemed medically unnecessary by the Medicare carrier, contrary to hospital policy or the Joint Commission on Accreditation of Health Care Organization Standards. Physicians are then put in the untenable position of being required to do something for which they will not be paid.

Other irrational results of Medicare regulations include HCFA policy toward

consultations and concurrent care. Many Medicare patients have complex medical problems that require the attention of more than one specialist in their particular illness. Unfortunately, under HCFA rules, the first consulting physician to submit a bill gets paid the consultant's fee and the specialist who submits a bill second gets paid only for a lesser hospital visit.

Why should this matter to the subcommittee and to Congress? Because if enough physicians become disillusioned with the Medicare program, patient care will suffer. You may recall the comment by the HHS regional administrator that physicians in Georgia have become so irritated that 150 of them have stopped seeing Medicare patients. Recently, a physician from New York wrote to ASIM, "My answer to the 'hassle factor' is to stay out of Medicare. I do not see nursing home patients nor do I see any new patients over age 64. Medicare is a disgrace and insult to me and my profession. The elderly will suffer but only their voices will be heard. Physicians' complaints to HCFA are a waste of time."

Numerous statistics and surveys support the contention that primary care is increasingly viewed by practicing physicians as well as medical students, as a less desirable field of practice than other types of medicine. For example, in a 1989 survey of internists in New York State, over 60% said medical record keeping is an increasing burden that has not improved the quality of care. (1) Over 50% said that paperwork associated with medical care is interfering with their practice. (2) Thirty-six percent of the sample said they would consider leaving practice. (3) In addition , the number and percentage of those graduating from U.S. medical schools choosing internal medicine resident programs decreased by 6 percent from 1985 to 1987. (4) Among the factors contributing to this decrease are the extensive mental and emotional involvement with patients required of internists, the low fees relative to other specialties, the office overhead which can

consume 60 percent or more of fees received, and the debts in excess of $50,000 many students have when they graduate from medical school. (5) In one study, internists spent 18 percent of their time on administrative tasks--time which could have been devoted to their patients. (6)

Few would disagree that when factory workers, teachers, government officials, nurses, office workers or business people become frustrated, angry and disillusioned with their jobs, their productivity and commitment diminishes. The same, of course, is true for physicians. The medical profession's commitment to their patients so far has protected the public from any harm that otherwise would have resulted from the government's policies. But if the administrative burdens required to serve Medicare patients increase unabated, ASIM has no confidence that this will continue to be the case in the future.

Improper denials and restrictive policies that make it difficult to obtain benefits really deny beneficiaries the benefits to which they are legally entitled. Even though Congress has insulated Medicare patients from the cost ramifications of those denials, the fact remains that, if physicians cannot be reimbursed for appropriate services, care will suffer.

Following to this testimony is a list of many of the administrative requirements imposed on physicians in the last five years. It is by no means intended to be a comprehensive list nor is it meant to imply that all of these requirements are bad from a public policy standpoint. However, Congress should be aware of the cumulative effect these administrative responsibilities are having, and will have, on physicians' abilities to care for their patients.

ASIM believes that relieving the "hassle factor" for physicians should be a priority public

policy issue addressed by Congress. In the coming months, an ASIM task force specifically designated to investigate the "hassle factor" will be looking at these problems from three perspectives: 1) identifying those administrative and regulatory burdens that are most troublesome to internists, 2) assessing ways for physicians to deal with and learn from those that are deemed necessary for appropriate patient care purposes and 3) seeking the modification or elimination of those "hassles" without any sound basis for maintaining and improving the quality of care given to Medicare patients.

ASIM invites the interest of the subcommittee in our efforts and would welcome the opportunity in the future to share with the subcommittee the results of our deliberations.

(1) Archives of Internal Medicine, Vol. 149, August 1989, 1745-1749, Charles O. Hershey, MD et. al.

(2) Ibid

(3) Ibid

(4) Annals of Internal Medicine, Vol 108, January 1988, 101-115, John S. Graettinger, MD

(5) New England Journal of Medicine, Vol. 317, August 26, 1987, 567-569, Daniel J. McCarty, MD

(6) New England Journal of Medicine, Vol 314, February 13, 1986, 441-445, David Himmelstein, MD and Steffie Woolhandler, MD

Examples of New Administrative Responsibilities Imposed on Physicians

1. Effective November 1, 1985, Medicare carriers are required to establish prepayment medical review screens to "flag" certain services for additional review before payment. Because HCFA will not inform physicians what the parameters of service are by releasing the screens, physicians have the same types of claims held for further review. When a physician successfully refutes a carrier denial based on a screen, no precedent is set. Thus, the same claim, on the same service, for the same patient can be denied repeatedly, even when the physician is proved right.

2. Effective October 1, 1987, non-participating physicians who provide, on an unassigned basis, services determined to be medically unnecessary by the carrier are required to refund to the beneficiary any amounts collected. Refund is waived if the physician notifies the beneficiary in writing in advance that Medicare would not pay for that particular service. (OBRA 1986)

3. Effective October 1, 1987, physicians must comply with PRO "Medical Necessity" refund requirements. For PRO denials of assigned claims based on medical necessity or substandard quality, physician must refund any amounts collected. For PRO denials of unassigned claims based on substandard quality, physician must refund to patient any amounts already collected, unless the physician has notified the patient in writing that Medicare may not cover that particular service or procedure. (OBRA 1987)

4. Effective October 1, 1987, non-participating physicians must provide, in writing to

the beneficiary, certain fee information for elective surgery over $500. (OBRA 1986)

5. Effective April 1, 1988, physicians are required to list the name address and supplier of purchased diagnostic tests as well as the amount charged on claims for payment. (OBRA 1987)

6. Effective April 1, 1989, complete ICD-9-CM Codes are required on all claims. Unassigned claims without such numbers or inaccurate numbers will be sent to IG for sanctions. Assigned claims without such numbers or inaccurate numbers will be denied reimbursement. (OBRA 1989)

7. Effective April 1, 1989, all PROs are required to conduct preadmission review on 100 percent of ten surgical procedures. Physicians must obtain from the PRO a "preauthorization number" which must be followed by a written confirmation of the number from the PRO.

8. Effective 1989 under a grace period, Unique Physician Identification Numbers will be required to indicate performing and referring physicians. Until they are available, provider numbers are required. (OBRA 1985)

9. PROs authorized to undertake physician office review. Pilot programs begun 1989 and will require copying and transmittal of office records to PRO, responding to PRO requests for additional information or questions about services. PROs to engage in "educational" activities for problems found with possibility that these will be forwarded to Inspector General.

10. Effective May, 1990, assigned claims submitted without the Medicare carrier identification number of the performing physician will be rejected

11. Physicians required to submit all Part B claims beginning September 1, 1990. (OBRA 1989)

12. Maximum Actual Allowable Charges (MAACs) revised. Physicians required to personally calculate their own MAACs to make sure carriers have not made mistakes. Some MAAC calculations required a five step formula for each service. (OBRA 1987)

13. Preadmission screening and annual resident review requirements intended to eliminate warehousing of mentall ill patients in nursing homes require the physician to complete questionnaires on all nursing home patients. (OBRA 1987)

14. Certificates of Medical Necessity. Completion of these are required by physicians for a number of home care services and equipment rentals. For example, OBRA 87 required, effective August 1989, a new Certificate of Medical Necessity (HCFA 484) for home oxygen rental. This form takes a physician approximately 15 minutes to complete. For certain durable medical equipment payments, (e.g. TENS) physicians are required to certify the need for this every two months.

STATEMENT

OF THE

GEORGIA CHIROPRACTIC ASSOCIATION

The doctors of chiropractic in the state of Georgia have attempted by every avenue available to resolve the problems which we, and our elderly patients in Georgia, are experiencing with the Medicare program. After AEtna Life Insurance Company was appointed the Medicare carrier for this state and subsequently hired HealthCare COMPARE Corporation to preform Part B utilization review, we have been faced with denials of valid claims for sick patients and are unable to determine the criteria which is being utilized for these denials.

One procedure, and only one - the *chiropractic spinal adjustment/manipulation*, provided to Medicare patients by the doctor of chiropractic is reimbursable under present Medicare guidelines. It would seem not too difficult, therefore, to determine the criteria for this one service to be reimbursed. Not so with AEtna and HealthCare COMPARE. AEtna sends denials on approximately 50% of the claims as being "medically unnecessary."

On nearly all of these denials, the patient is advised to ask for a refund of any monies he may have paid for these "unnecessary" services. These notices are sent to the patient frequently without having asked for further information. Much of the time when further information is requested, the information requested is clearly evident on the original claim form.

In cases when new or additional information is sent to the carrier, the claim is still denied with the statement that: "a specially-trained person made a new and separate review" and found the first decision to be correct. When a hearing is requested the request appears to fall into a black hole. No further word is heard.

ATTEMPTS TO RESOLVE PROBLEMS

The chiropractic profession, nationwide, is already hampered with the unfair restriction that all care for medicare patients must be based on findings of x-rays, which are a non-covered service under Medicare, and ONLY the spinal adjustment is a covered service. This restriction is one placed on the chiropractic profession by the Health Care Financing Administration (and it's forerunner in the 1960's) in writing the original guidelines for chiropractic participation in Medicare. This stipulation was not a part of the law which was passed by congress to include chiropractic care in Medicare.

With the appointment of AEtna and HealthCare COMPARE, chiropractors in Georgia have found it nearly impossible to care for the elderly citizens of this state, and abide by the unclear, and sometimes nonexistent, rules of the carrier in order to get even this one service reimbursed.

Starting in the fall of 1988, the Georgia Chiropractic Association (GCA) has met and corresponded with AEtna and HealthCare COMPARE, and finally with the Health Care Financing Administration, and with members of Congress in attempts to develop a dialogue which would lead to some clarifications of the Medicare dilemma for the chiropractic patient and the doctors of chiropractic in Georgia. Our concerns have not been addressed as of this date, and there has been no improvement in the claims processing. Therefore, the GCA wishes to point out that AEtna and HealthCare COMPARE are not administering Medicare claims in a manner consistent with the regulations outlined in the Medicare manual and in so doing they are denying reimbursement to the recipients for covered services.

The GCA Medicare Committee has met and corresponded with HealthCare COMPARE on a frequent basis in an attempt to assist both the practitioners and their elderly patients with up-dated information regarding Medicare benefits, the present constraints affecting their care and the requirements for filing claims. To date we have met with these very nice people who assure us that everything will be straightened out. We receive extremely long, wordy letters which quote the Medicare manual but answer none of the questions asked.

WHAT DOCUMENTATION

This association has asked repeatedly of AEtna and HCC: *What they would accept as **documentation** for the medical necessity of a chiropractic adjustment.* No response has been supplied. We submit that compliance with the Social Security Act statement *"a physician/supplier knew or could reasonably have been expected to know that the services were excluded"* is not true and is not possible until this question has been answered. How is the practitioner to know when the persons processing the claims will not address the issue?

The Medicare Manual states in 2251.5 *TREATMENT PARAMETERS. "The Chiropractor should be offered the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation problems may require as much as 3 months of treatment, but some require very little treatment. In the first several days, treatment may be quite frequent, but decreasing in frequency with time or as improvement is obtained.*

"Chronic spinal joint condition implies of course, the condition has existed for a longer period of time and that in all probability the involved joints have already 'set' and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency. Carriers should develop parameters under which an extension in the course of treatment could be supported based on special documentation."

The above does give a carrier the right to develop parameters and to require documentation specifically to extend treatment. However, obviously it was not intended to give the right to develop parameters and to require documentation to elude reimbursement of covered services, nor to require documentation without some form of explanation of what is acceptable.

The Medicare Manual also mandates 2250 - *"Implementation of the Chiropractic benefit requires an appreciation of the disparate orientation of the Chiropractic theory and experiences as those of traditional medicine since there are fundamental differences regarding etiology and theories of the pathogenesis of disease.*

Judgement about the reasonableness of Chiropractic treatment should be based on the application of Chiropractic principles, so that Medicare beneficiaries receive equitable adjudication of their claims based on such principles and are not deprived of the benefits intended by the law."

Claims are routinely denied with the statement that "the documentation does not support the medical necessity for the visit, visits, or services, etc." What are the qualifications of the person who makes this determination?

The most recent attempt to drive the chiropractic patient out of the Medicare program is the denial from AEtna which states: "This doctor is not a participant in the Medicare program and therefore no reimbursement can be made to him. We will provide you with a list of participating physicians...." We are not aware of any Medicare regulation which REQUIRES PARTICIPATION. Medicare recipients may choose any doctor and receive reimbursement although those doctors who choose not to "participate" are penalized in the amount of reimbursement.

Error? Yes, this is obviously an error. How much longer must we wait for AEtna to get their people trained. How much paperwork, frustration, time and effort must be endured to effect the small amount of reimbursement for the ONE COVERED SERVICE ALLOWED CHIROPRACTIC Medicare recipients?

The GCA respectfully requests that Aetna and/or HCC be required to administer the chiropractic Medicare claim in Georgia in accordance with the published regulations and if changes or additional special documentation is to be required that these rules or regulations be provided as requested, or published to the entire chiropractic community in Georgia.

CLAIMS REVIEW

It is our understanding, that HCFA required AEtna to hire the for-profit corporation, HealthCare COMPARE to provide claims review. The GCA maintains that Medicare regulations require that chiropractic claims be reviewed by those experienced in the etiology and theories of chiropractic - in other words by PEERS. This association respectfully maintains that nurses, retired medical doctors nor the one retired doctor of

chiropractic on the staff of HCC are NOT CHIROPRACTIC PEERS.

In our attempts to provide advice and assistance to insurers, patients and others dealing with the chiropractic profession, the GCA has established committees to serve in these areas. The GCA has an established PEER REVIEW COMMITTEE, composed of doctors of chiropractic actively practicing in Georgia. Both AEtna and HCC have been advised that this non-profit committee is ready, willing, and able to assist with claims review or other information needed by the carrier to implement the Medicare regulation as regards special documentation, frequency of care and necessity of care. There has been no response from either AEtna or HCC regarding this.

It is the position of this association that AEtna, HealthCare COMPARE, and possibly the Health Care Financing Administration, has conspired to discriminate against the Medicare recipients in Georgia who choose chiropractic as an alternative health care. We do not believe this is the intent of Congress.

Much information regarding chiropractic which has been provided to Congress, the public, and the medical community has been flawed. Much misinformation was intentionally provided as has been shown in the Federal Court trial of Wilks vs AMA. This is a Federal antitrust case in which a group of chiropractors sued the AMA and other medical groups for having attempted to destroy the profession of chiropractic. The medical groups were found guilty in the United States District Court, a judgement which was affirmed by the U.S. Court of Appeals for the Seventh Circuit in Chicago, Illinois on February 7, 1990.

7

Since the advent of the Wilks suit fourteen years ago, there have been many unbiased studies showing the efficacy of chiropractic and the fact that chiropractic care is more often successful in the treatment of musculoskeletal conditions, without drugs, or surgery and therefore, lower costs, than other health care providers.

It would seem that reason dictates that any cost reduction efforts by Medicare would encourage chiropractic care for the elderly since many of their ills have to do with the musculoskeletal system, rather than attempts to make it difficult for those elderly citizens who choose chiropractic care.

In addition to the above insults to the Medicare patient who chooses chiropractic care to regain his health, and the distrust manufactured by the carrier between the Medicare patient and the doctor of chiropractic, this carrier has taken it upon themselves to address the doctor of chiropractic in their mailing as "CH." I am referring to the recent innovation of address such as: *"Joe Jones CH"* on newsletters and other mailings from AEtna Medicare.

The chiropractic profession most strongly protests this form of address for doctors of chiropractic in this, or any other state. Those who represent any governmental agency for the citizens of this nation should know, or "could reasonably be expected to know" that the proper form of address for the largest drugless health profession in this nation is "Dr." or "Doctor" before the name, or "D.C." after the name of a doctor of chiropractic . NOT "CH"

This last item may appear to be a small thing. This is very illustrative of the knowledge this carrier has of the chiropractic profession and is just another example of

their lack of knowledge in administering the Medicare program.

Please find attached specific questions which need answerers and specific areas of contention with AEtna Medicare and with HealthCare COMPARE.

CLARIFICATION NEEDED

1. What constitutes necessity for a chiropractic spinal adjustment?

2. Who makes the determination on medical necessity on chiropractic claims? What are the *chiropractic* qualifications of the person making this determination?

   Attention is called to the following excerpts from the Medicare manual

   "Selection of consultants in the pertinent fields of medicine for expert input into the development of medical guidelines and the preparation of selected MR determination;" is a REQUIREMENT

3. What chiropractic group or groups have been invited to present comments regarding recommendations for specific parameters associated with implementing the policy at the carrier level?

   Medicare Manual: *"Invite comments from the state medical society and appropriate specialty societies on the proposed policy changes....."*

4. Only one service provided by the doctor of chiropractic is COVERED under medicare. This distinction should be noted in correspondence with Medicare recipients. Current notices indicate that the doctor of chiropractic should not be allowed to collect any monies from the patient above the amount approved by Medicare, when in fact, x-rays, examinations, therapies and other services may have been provided to the patient for which THE CHIROPRACTIC MEDICARE PATIENT MUST BEAR THE COST HIMSELF.

We have read and understand the following points which are contained in the Medicare manual and have no need to have this repeated by HealthCare COMPARE.

The GCA recognizes the limitations placed on Chiropractic reimbursement in the Medicare Manual as follows:

- "The term physician under Part B includes a Chiropractor who meets the specified qualifying requirements set forth in 2020.26, but only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist)."

- "Coverage of Chiropractic services is specifically limited to treatment by means of a neuromusculoskeletal condition necessitating treating the patient's condition."

- "The symptoms must bear a direct relationship to the level of the subluxation."

- "Limited to one treatment per day unless documentation of reasonableness and necessity for additional treatment is submitted with the claim."

- The Health Care Financing Administration form 1500 must be completed and legible with all published required information.

- The GCA is not asking anyone to establish utilization frequency guides.

RECOMMENDATIONS

1. **Require the carrier,and anyone acting for the carrier, to provide substantive answers to questions involving reimbursement and/or the lack of same.**

2. **Require that judgments regarding reasonableness of chiropractic care be based on the application of chiropractic principles, so that Medicare beneficiaries receive equitable adjudication of their claims based on such principles and are not deprived of the benefits intended by the law.**

3. Require the carrier, and anyone acting for the carrier, to administer the Medicare claims be administered according to regulations published in the Medicare manual.

4. We respectfully request that Chiropractic be treated as other health care professions and that x-rays and examinations which are required by law to be provided to Medicare recipients be a COVERED SERVICE in the Medicare Program..

Albert A. Carr, MD, President
Georgia Society of Internal Medicine
a component Society of the American
Society of Internal Medicine

The statements and requests written in this report were based on my interpretation of data, letters, literature reviews, information obtained from meetings of the Georgia Society of Internal Medicine (GSIM) Council, GSIM communications with the American Society of Internal Medicine (ASIM), GSIM meetings with the Georgia Medical Care Foundation (GMCF) peer review organization, actual peer review of physicians in internal medicine for GMCF by the GSIM Council, GSIM communications with Joseph P. Bailey Jr, MD of the Medical Association of Georgia, Aetna, Health Care Compare Corporation, Aging connection - Augusta, GA (managed by the Resource Center of Aging in Augusta, GA), Georgia Silver Haired Legislative Delegation (Virginia Zachart, M.D.) review of data from the Health Care Finance administration (HCFA), my own active internal medicine practice (Hypertension Cardiovascular Disease and Endocrinology and Primary Care), and review of testimony by others to this Committee on March 5, 1990. I am Professor of Medicine and Pharmacology and Chief, Section of Hypertension, Department of Medicine, Medical College of Georgia, Augusta, GA. I also am Director of the Endocrine Diagnostic Lab, Laboratory Medicine, Medical College of Georgia. I am a past President of the Richmond County Medical Society and Georgia Association of County Health Departments. I am presently chairman of the Richmond County Health Department and serve as a Regent of American College of Clinical Pharmacology. I am a graduate of the University of Virginia School of Medicine and received my postgraduate clinical training for internal medicine at the University of Virginia Medical Center Charlottesville, VA

and research training at the National Heart Lung and Blood Institute, Bethesda MD. I have been certified for internal medicine by the American Board of Internal Medicine. I have been involved in academic medicine all of my professional life and currently am actively involved in the practice of medicine and clinical research. My experience involves teaching, research, active practice of medicine, public health and administration. I am currently President of GSIM, a state component society of ASIM.

Statements:

There are 420 active members of GSIM. We also have members in their post graduate medical education training (internship, resident, and fellowship appointments in the Departments of Medicine - Internal Medicine). There are around 8,900 physicians in Georgia engaged in the active practice of medicine. At this writing I am not sure as to how many physicians in Georgia are in specialty of internal medicine or primary care.

Internists, general and family practitioners, and obstetrician-gynecologists are the specialties which provide most of the primary care or primary medical evaluation and management (EM) for the Medicare beneficiaries. Primary care provides overall EM and record keeping for a beneficiary. Some of the EM may be obtained by requests from the primary care physician to other physicians and services (consultation, referral, concurrent care). Primary care involves record keeping and retrieval source for all of the medical care (medical history) plus the medical EM provided by the

primary care physician and other physicians and services. Primary care is an integral component of the discipline and specialty of internal medicine. The internal medicine specialist has a high order of EM skills over a broad spectrum of human diseases and dysfunctions. Physicians trained in internal medicine have sufficient knowledge of the broad services and skills of the specialties and subspecialties of medicine so they can intelligently select and critically evaluate the specialty and subspecialty needs of their patient. Training in internal medicine allows for the provision of highly skilled primary care and the capacity to deal with complex medical problems. The postgraduate medical school supervised training is a minimum of three years. Many of the subspecialties of internal medicine require two or more additional years of training provide primary care. My statements and requests are given from the perspective of internal medicine in general and primary medical care in particular.

Several definitions of physicians' services for Medicare beneficiaries are needed for this report.

Attending Physician

This is the physician responsible for the hospitalization EM of a patient. This may not be the admitting physician. Some hospitals have Emergency Services Departments for EM of urgencies and emergencies. Once the patient is hospitalized the Emergency Services physician is most likely not the attending physician.

Consultation Physician

The attending physician is responsible for consultation requests to other physicians. The consultant physicians help with certain specified aspects of EM. In emergency situations the attending physician may not request the consultation.

Referral Physician

The attending physician may request transfer (referral) of the patient to another physician. The referral physician becomes the attending physician when the referral is accepted. The original attending physician then may be involved as a consultant or in a concurrent care situation.

Concurrent Care

When two or more physicians are required to be involved in the EM of the same patient during a hospitalization.

Level of Service

Time, type and complexity of illness - new, stable or change, site and time of day are important determinants for the level of service. The Physician Payment Review Commission (PPRC) as mandated by Public Law 99-272 reported to congress in April 1989. It suggested new ways to provide payment for physicians' services with some equity among geographic areas with possible protection of beneficiaries' access to medical care and at the same time slow the rate of rise in expenditures. The suggestion was a new Medicare Fee Schedule (MFS) based on resource costs which reflects physician work time, intensity of effort and practice cost (other than net income described as the Resource Based Relative Value Scale (RBRVS).

Physicians supplying internal medicine and primary care services have long believed that time before, during and after contact with the patient, the stability of the patient's medical problem(s) and whether old or new, and the site of service are the major factors which should determine amount or rate of reimbursement. The physician's skill and cognitive abilities in evaluation and management are also important determinants. All of these components can be measured and documented with some accuracy; 1) time, 2) type of illness - new, stable or change, 3) site of service and 4) post graduate medical school training (formal training and continuing medical education - CME). Practice costs are another component which can be documented and are important.

Levels of service

Minimal, brief, limited, intermediate, extended and comprehensive are generally accepted as descriptions that involves each level and the dollar reimbursement currently is being debated.

Over the past year since January 1989, in Georgia new interpretations and implementation of Medicare Laws related to physicians' services by the carrier for Part B, Aetna and Health Care Compare Corp. have resulted in delayed and reduced payments to physicians especially those providing primary care and internal medicine. This has been due to slow processing claims, down grading or denial of charges (special emphasis was on denial of reimbursement for comprehensive services, and often denial of reimbursements for EM related to concurrent or consultant care).

The denials and downgradings were unilateral on the basis of interpretation of codes and what should be considered necessary by Health Care Compare and Aetna. Physicians in Georgia were given little warning or explanation of these changes and no effective involvement in the methods used to determine these changes. These denials, reduced rates and slow reimbursements have caused some Internal Medicine specialty practice physician to change from individual or small group practices to hospital based or corporate or HMO practice. This change is important because the result will be increased expenditures for outpatient (ambulatory care) EM for Medicare beneficiaries. This is because facility fees in excess of $47 per visit will be paid to hospitals through Part A for outpatient services. Although Part B physicians' services are reduced to 60% of allowable (80% of that for HCFA) the overall cost of Part B plus Part A (for the facility) is significantly greater. Therefore the more efficient method of providing ambulatory EM by the primary care physician in individual or small group practice as compared to hospital based care is being destroyed. Aetna and Health Care Compare by their actions are making it more difficult to obtain primary medical care (EM) and forcing Medicare beneficiaries to obtain medical care from hospital based and expensive highly specialized procedure oriented types of physicians' services. In 1986, 21.4% of all physicians' services were provided by internal medicine physicians yet this represented only 13.8% of the total expenditures. In contrast 20.1% of the services supplied by surgeons, radiologists and anesthesiologists accounted for 41.8% of the total expenditures.

Helbing C, Keen R. Use the Cost of Physician and Supplier Services Under Medicare 1986. Health Care Financing Rev 1989;10:109-122.

Over the four year period 1983 to 1986 only 18% of the total of increased expenditures for physicians' services was by internists. In contrast 56% of the expenditures was for surgeon and radiologist services. Non invasive diagnostic services accounted for 11% of expenditures.

Source: Mitchell JB, Wedig G, Cromwell J. The Medicare Physician Fee Freeze. Health Affairs 1989;8:21-33.

It is of interest that 19 billion dollars were spent by Medicare for physicians' services in 1986. Internal Medicine accounted for 2.6 billion dollars or 13.8%. Net income after expenses and before taxes was 52% or 1.35 billion dollars; 537 million dollars was for salaries of office personnel. Thus a total of 1.89 billion dollars for salaries was taxable at a rate of at least 20% or 378 million dollars. Therefore, the real expenditures by our government was less than it seemed. The percentage of total physicians' services by internists for Medicare accounted for 13 to 14% of total expenditures and the rate of rise since 1978 has been small.

In 1988 dollars net income for those physicians in internal medicine was $98.1 thousand dollars per year; in 1984 $100.7 and

1987 $103.1 thousand dollars. From 1978 to 1983 a 1.2% decrease; 1984 to 1987 a 2.4% increase.

Based on the above, it seems unfair in Georgia to initiate a reimbursement system for physicians' services which reduces further reimbursements for services provided by physicians in internal medicine. Furthermore, it will not be of much value in cost containment of overall physicians' services for Medicare! Total income and income per hour is less for primary care as compared to surgery and procedure oriented physicians.

Figure 1 compares the median net income after expenses and before taxes of radiology (radiol), surgery (surg), anesthesiology (anesth), internal medicine (IM), general practice (GP), and pediatric (Ped) physicians from 1978 to 1987 in 1988 dollars.

Source: "Trends, Variations and Distribution of Physicians Earnings.", in Socioeconomic Characteristics of Medical Practice 1988. ML Gonzales and DW Emmons eds, American Medical Association, Chicago, 1988.

Over the ten year period 1977-1988 the increase in physicians' services expenditures were due to increased utilization and increased charges. However, the rise in expenditures has been due to services of physicians not in primary care (Surgeons, Radiologist, Anesth.).

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MEDIAN

NET INCOME AFTER EXPENSES BEFORE TAXES

1988 DOLLARS
per year

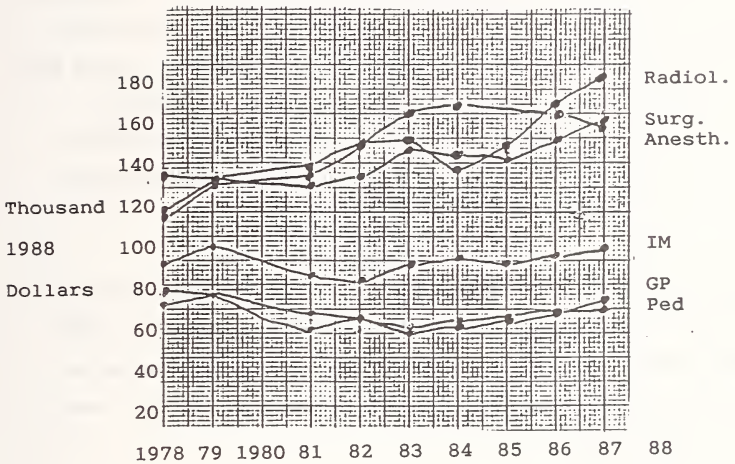


Figure 2 shows the net income per hour of work after expenses and before taxes. It is of interest that internal medicine, general practice and pediatric physicians have remained constant at $28 to $32 per hour since 1982. Internists have maintained a relatively constant net income by increasing the hours per week worked and number of visits or services. Most work in excess of 60 hours per week. In contrast radiology, anesthesiology and surgery physicians' income has increased. Also is of interest when one takes their automobile in for repairs to a dealership the labor charges are in excess of $40 per hour.

The median net income of physicians providing internal medicine services has not changed much since 1978 when expressed in 1988 dollars (takes into account inflation). In contrast the median net income for radiologists, surgeons and anesthesiologist have markedly increased.

The internal medicine physicians and especially those providing primary care are being discriminated against in Georgia both by prospective denial or reduced reimbursement plus post payment review. It is of interest that since prospective payment system with DRG's (1984) the rate of rise in expenditures for Part A has slowed but Part B has increased. The change in slope for Part B physicians' services expenditures changed only slightly from 1.5 in 1979 to 1983 to 2.15 in 1984 to 1987. See Figure 3.

FIGURE 2

NET INCOME AFTER EXPENSES BEFORE TAXES
1988 DOLLARS

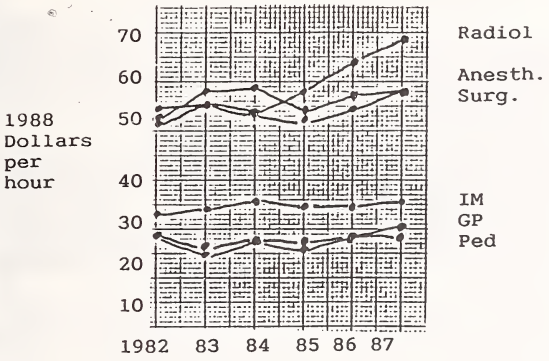
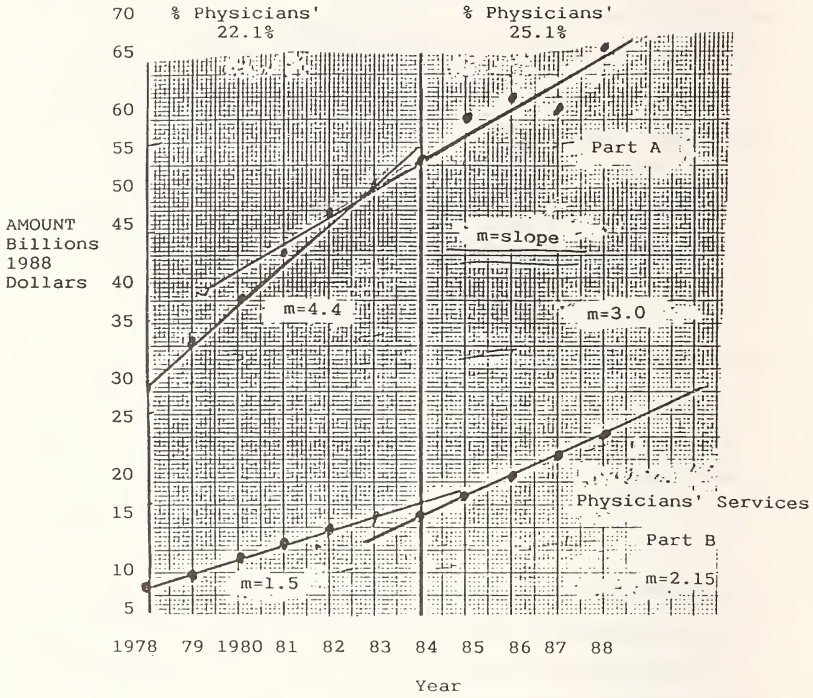


FIGURE 3

BILLIONS OF 1988 DOLLARS



Among other things a so called inordinately increased rate of comprehensive level of services by Georgia physicians prompted HCFA and Aetna to launch a pilot program in Georgia to determine if cost could be contained by denying "so called" unnecessary comprehensive and concurrent care services. George Holland, Regional administrator, Atlanta Regional Office in his March 5, 1990 statement claimed "HCFA data from 1987 showed inordinately higher rates of comprehensive visits billed in Georgia compared to national rates. Susan A. Stallings, Manager of Aetna Medicare Part B Claim office in Savannah Georgia, March 4, 1990, Atlanta Journal and Constitution, page G-2, stated, "HCFA reviews of Medicare charging practices show that Georgia physicians, on average, billed for comprehensive services 23 percent more often than their peers in other states! (Yet neither related the services to severity of illness of the patients)

It may be true that Georgia physicians make more claims for comprehensive services. However, neither HCFA nor Aetna has allowed others to review their data. As I recall, Prudential, the Part B Medicare carrier for Georgia prior to January 1, 1989 used a four digit code rather than the five digit code for the level of physician services. Prudential lumped minimum, brief, limited, and intermediate services of the five digit CPT codes into one four digit code. They instructed physicians in Georgia to submit CPT codes of comprehensive so they could get reimbursed at a dollar value close to that for a limited service. The lumping by Prudential of the five digit CPT codes to a lower four digit code

caused marked under reimbursement and over reimbursement for intermediate and brief services respectively. In 1986 or 1987 Prudential switched to the five digit CPT code based on September 1985 data. A report from the office of the Inspector General "Problems with coding of Physician Service: Medicare Part B for 1986 showed the percent of total (frequency) of established outpatient office visits for comprehensive over the nation to be 4%; In Georgia 1988 it was 3.93%. The switch over to CPT was in 1986 or 1987. If in 1986 the comprehensive was 4% for the nation a 23% increase by Georgia physicians would be 4.92%. There must be some error by HCFA or misinterpretation of their am dates. This mandates that other review their data about levels of service. The Inspector General report stated: "The nature of the coding problem was examined in interviews with HCFA and carrier staff. The interviewers revealed that the principal reason for variations in billing patterns among carriers is the difference in interpretation of codes by both carrier and providers. When carriers first converted to HCPCS, HCFA permitted them considerable flexibility in translating codes under their old systems into the new CPT codes. This flexibility led for example, to some carriers converting an old 9004 ("routine follow-up office visit") to the CPT code 90040 (Brief) while others converted this code to CPT code 90050 (limited). Variations in how carriers converted their old coding systems into the new are most evident in the differences in what CPT codes chose to designate the "routine" level for office and hospital visits." "Lack of uniformity in the coding of routine services causes providers to

lose confidence in both the carriers and the Medicare program." Based on the above HCFA and Aetna should compare frequency of various levels of service (in particular comprehensive) of Georgia Physicians to other states where Prudential was the carrier and used the same codes and interpretations prior to and after the conversion from their four digit to the CPT five digit code. In addition the Georgia physicians should be compared to physicians in other states with similar death rates due to one of nine chronic disease (stroke, coronary heart disease, diabetes, chronic obstructive lung disease, lung cancer,m female breast cancer, colorectal cancer or cirrhosis). Such states are Indiana, North Carolina, Pennsylvania, and Tennessee. MMWR 1990;39:17-20. JAMA 1990;263:798-800. Also, comparison should be made to states with similar prevalences of Medicaid an index of poverty.

Request: I respectfully, ask the Committee to Instruct HCFA and Aetna to supply to me the frequency data on levels of services in Georgia for both fiscal and calendar years 1985, 1986, 1987, 1988 and 1989 and compare this to the states of Indiana, North Carolina, Pennsylvania and Tennessee and determine if they are statistically significantly different.

Statements:

On March 5, 1990, Mr. Holland stated that in calendar year 1988 Medicare paid Georgia physicians 692 million dollars. Susan A. Stallings stated that January - September 1989 Aetna saved the Medicare Trust Fund 15 million dollars. On a year rate this would

be 20 million dollars. She also stated that when denials or down codes were challenged there was a 50% reversal of the decision. Thus if all were challenged they would have a savings of 10 rather than 20 million dollars. The savings represented 1.44% of the physician services expenditures 1988. The office of Inspector General report on March 5, 1990 claimed that Health Care Compare and Aetna were 90% correct in their evaluation of claims. This was based on a "statistical sample" of some 450 claims. It is curious however that when decisions by Health Care Compare or Aetna challenged there was a 50% reversal. Something must be wrong with the report by the Inspector General Office.

The following table is from the HCFA Carrier Work Load Report and Reasonable Charge and Denial Rate Reports FY 1989.

	Aetna GA	National
% claims denied in part or in full	18.8	17.5
% denied as medically unnecessary	14.2	13.8
FY 1989 % of claims from Participating doctors processed within 15-18 days	67.1	91.2
% of all claims processed within 15-25 days	74.5	93.6
% of all claims processed within 60 days	92.4	93.6
% of appealed claims resulting in reversal	62.8	54.2
% of claims coming before ALJ resulting in reversal (Jan-Sept 1989)	40.5	39.3

On March 5, 1990 the office of Inspector General claimed in Georgia the vast majority of beneficiaries were satisfied with the performance of Aetna. However, 85% of all claims in Georgia were assignment accepted. Yet the survey by the Inspector General did not take this into account and separate those with and without accepted assignment.

REQUEST: I respectfully ask if the Committee will request HCFA or the office of Inspector General to furnish me the dollars paid to physicians in Georgia via Part B for calendar year 1989 and the dollars of denials or down coding by Aetna.

I would like the office of Inspector General to supply to me the statistical method by which claims were pulled to be evaluated by a "private" medical consultant. I would like to know the qualifications of that consultant. Is that consultant in the active practice of medicine? If possible I would like to know the name of that consultant and a Curriculum Vitae.

I respectfully ask the Committee to request the office of Inspector General to survey beneficiaries (with assignment not accepted) in terms of their satisfaction with Aetna.

OTHER SUGGESTIONS:

1) Comprehensive Care: The latest revision by Aetna via Health Care Compare Corp. solves the problem related to excessive denials of comprehensive services. In CPT-4, skill, effort,

time, responsibility and medical knowledge are used with new or changing medical conditions and are all important determinants of service level.

It is suggested the following be considered as a condition for comprehensive level of service:

1) Time - 45 to 90 minutes. Which includes pre and post patient contact review of data and patient contact time.
2) Primary care physician and internist documentation.
3) ICD code for stable medical condition
4) After initial comprehensive level of service; subsequent charges for comprehensive care would require ICD code of a change in stable medical condition (example - stable to unstable angina pectoris) requiring 45 to 90 minutes of physician time and ICD code for new medical condition (examples acute myocardial infarction and from angina or diabetic ketoacidosis from non-accelerated essential hypertension.

If not the primary care physicians 45 to 90 minutes of physician time perhaps could be an extended level of service.

The frequency of comprehensive level of services charge by a physician in internal medicine depends on medical condition (stable to unstable or new) and time required by physician for

evaluation and management (45 to 90 minutes). This would require ICD code for old unstable or new medical condition, a note stating 45 to 90 minutes of the physician's time required and whether primary care and internist.

2) Attending Physician: The name of that physician should be noted on the hospital record and the charge for services identified as by the attending physician. An ongoing charge profile should be kept on attending physicians and if level of service charges are outside what is usual a retrospective review of practice habit should be initiated. Appropriate action should be taken on the basis of the review. Denial of claim reimbursement should not be part of the Part B activity.

3) Primary Care Physician: If the primary care physician is the attending physician this should be noted on the charge.

4) Consultation Physicians: This physician and service should be noted as consultation. The charge should be identified as consultation. I suggest at least two days of follow-up after the initial visit. If further EM is needed the attending physician should request another consultation.

5) Concurrent Care: The attending physician should be always identified on a charge. The concurrent care physician should be identified in the progress notes and charges identified as concurrent care. It should be up to the concurrent care

physician to justify need for continued follow-up. The attending physician should not need justification unless the charge profile shows abuse.

6) A profile on consultations and concurrent care required by an individual attending physician could be used to determine normal usual practices.

The concurrent care should be for only one diagnosis. The attending physician care charges could be for one or more conditions including the one for the concurrent care physician(s).

7) All charges should have: If either consulting or concurrent care physician the name of the attending physician and the ICD-9-CM code for disease or condition in addition to the CPT code.

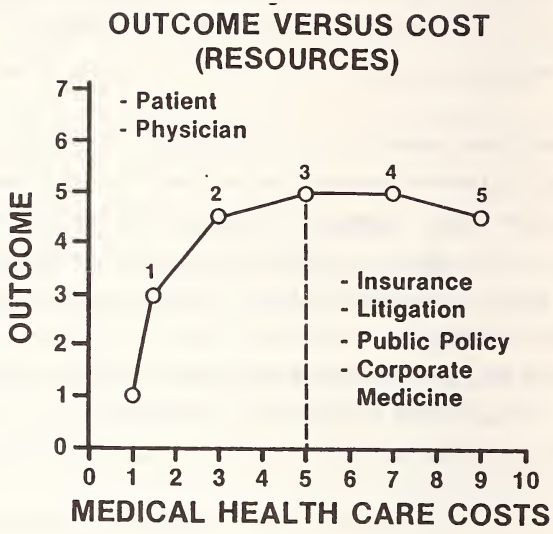
In my opinion claims for primary care and attending physicians' services should be reimbursed in a timely manner and should be first in order of consultants and concurrent care services reimbursements. If primary care physicians and internists in particular are forced out of individual or small group practices by primary denial and reduced reimbursements for services then HCFA will face increased cost for care of Medicare beneficiaries. This is because the beneficiaries will be forced to obtain care from the more expensive hospital or corporate based practices and the increased use of subspecialty services without adequate

planning and coordination. In addition the cost savings to HCFA by these denials or reduced reimbursements will be much less than if procedure and technology oriented services are reviewed. Also there may be less access to reasonable EM for Medicare beneficiaries.

The legislation created by P.L. 97248 makes it mandatory for Medicare to eliminate payment for unreasonable, unnecessary, and inappropriate care. However, it does not address the question of quality of care and is perceived more as cost containment than what is best for the beneficiaries. If there are limited resources it should be so stated. There is no reason to spend more money when outcome cannot be further improved by that added money. This is shown in Figure 4. Beyond point 3 at a cost of 5 it makies no sense to expend more.

Quality of Care can be defined as: intensity and appropriateness of medical services according to current scientific knowledge which can provide outcomes consistent with resources available from Medicare. Thus, outcome depends not only on the application of scientific knowledge but the resources made available by public policy decisions. Clearly, means and outlier profiles are important methods of determination of need. However, severity and type of illness each is important.

FIGURE 4



Carr AA. Reimbursement for primary and cognitive physician services. J Med Assoc GA 1986;July:440-445.

REQUEST:

I respectfully request the Committee instruct HCFA to:

1) Supply a policy manual to Georgia physicians which includes definitions of level of services, concurrent and consultative care, necessary and unnecessary services and reasons for denials of services and down grading of services.

2) Make sure only physicians of Georgia License provide physician care for Medicare in Georgia.

3) Physicians in Georgia through their designated leaders should be involved with HCFA and the carrier in the determinations of definitions levels of services and need of services.

RESPONSE

OF THE

MEDICAL ASSOCIATION OF GEORGIA

The testimony of the Office of Inspector General to the Subcommittee on Health and environment was disappointing for several reasons. The first was that, while claiming and commissioned to be impartial, the Office of Inspector General gave advance copies of their report and testimony to both HCFA and AEtna Insurance Company, so that they could use the results in the public testimony. The same courtesy was not provided the Medical Association of Georgia. We can only conclude that the Inspector General determined that his investigation into the Georgia Medicare debacle is to be another instrument of HCFA and AEtna to cover up what is actually happening, and to deny the members of the Subcommittee accurate information.

This belief is further strengthened by the fact that the study was conducted contrary to the way beneficiary satisfaction surveys have been conducted in other states.

The purpose of the report was to survey beneficiaries of the Medicare program in Georgia as to their satisfaction with the services of the Part B carrier, and to then compare the results to a national "Survey of Medicare Beneficiary Satisfaction" conducted in 1989 and see if there were "significant differences."

Were the study to be impartial and useful the survey would have been conducted in the same manner as the national study. In the national study, beneficiaries were divided into two groups -- those who filed their own claims, and those whose physicians filed the claims because they took the claim on assignment. In Georgia, according to the testimony of the Office of Inspector General, they lumped both assigned and unassigned beneficiaries together because Georgia physicians accept assignment at such a high rate. In other words, since Georgia physicians handle 85 percent of all claims processing for their Medicare patients, the study appears to be a study of how Georgia physicians handle claims for their patients. Interestingly, 85 per cent of Georgia beneficiaries are satisfied with the claims processing -- the exact per cent that let their doctor handle their claims! It appears that the other 15 percent -- those who have to file their own claims -- apparently are as unhappy as the physicians who have to deal with AEtna!

One section in particular, on page C-1 of the report, is most intriguing. It states:

> In summary, because of the differences in the proportion and type of respondent answering the questions, and the differences in wording of the questions, it is inappropriate to make direct comparisons between the two surveys for these questions. [Emphasis added]

The next section then reads:

How Beneficiaries Responded in Georgia and Nationwide

The questions asked in both surveys, and the responses, follow:

At this point, the report provides the comparisons between Georgia and the nation -- immediately after stating such comparisons not only could not directly be made, but were "inappropriate."

Finally, when one studies the results of the survey, even accepting the flawed results on face value, the conclusions and testimony do not match the results.

This conclusion is reinforced when examining the responses to the individual questions asked the beneficiaries. The testimony revealed a very high level of satisfaction of Georgia's beneficiaries, especially when (inappropriately) compared to those nationwide. In reading the report however, one would be lead to different conclusions. For example, in trying to call AEtna to get answers about their claims, 70 per cent said that the line was busy and that was a problem, 56 per cent said they were put on hold too long, 34 per cent said AEtna gave answers that were not understandable, 28 per cent said that the answers they got were not answered at all, 16 per cent said the answers were incorrect, and 23 per cent said that the AEtna person was "Not very courteous". Are these the responses of satisfied citizens?

Perhaps because the appeals process is so complicated, expensive, frustrating and time-consuming to the elderly, only 8 per cent chose to appeal a claim. However, contrary to what the Inspectors General's Office would have us believe, 60 per cent disagreed with the final decision, 46 per cent didn't understand the final decision, and 62 per cent said the process took too long. Overall (and remembering that doctors account for 85 per cent of the claims filed), 40 per cent were either very dissatisfied or generally dissatisfied with the appeals process. That may be a satisfactory number to the Inspector General, but most private businesses would be out of business with that percentage of dissatisfaction.

Other high levels of dissatisfaction were also noted in the numbers of beneficiaries who had experienced one or more problems (62%), problems with the amount paid (40%), re-submission of claims (25%) and trouble filling out the form (20%). In the survey's one open-ended question, a total of 33% beneficiaries expressed negative responses regarding the AEtna operation. We would further question whether a sample of 491 would be truly representative of the total of 338,857 who had claims filed in 1989.

The Office of Inspector General has been known for its integrity and impartiality. In fact the mission of the Office of Inspector General "is to promote the...integrity of programs in the United States Department of Health and Human Services (HHS)." This report, which was conducted differently from other reporting the interpretation that was obviously flawed, and the advancement of copies of the report to HCFA and AEtna should raise serious questions to Congress and the Secretary of HHS about the credibility, the integrity and the impartiality of the Office of Inspector General.

In conclusion, we ask the members of the Subcommittee to examine the survey conclusions very carefully. The data generated and the conclusions drawn from that data are clearly flawed. What may be acceptable behavior by the Inspector General, and what may be acceptable levels of beneficiary satisfaction to him, is not to us; and hopefully, is not to Congress or the American people.

Georgia Association of Medical Equipment Suppliers
2323 Perimeter Park Drive, #110 Chamblee, GA 30341-1303 (404) 986-0637

3-14-90

Chairman Henry A. Waxman
Subcommittee on Health and the Environment
2415 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Mr. Waxman:

I am submitting these written comments in hopes you will allow them to be added to the record of your Public Hearing on Part B Medicare Carrier issues in Georgia. I am writing them on behalf of the Georgia Association of Medical Equipment Suppliers, (GAMES). We represent over two hundred (200) home medical equipment providers that serve the full range of home medical equipment service needs, for over 75% of Medicare beneficiaries in Georgia. Most members usually take Medicare assignment and therefore are very sensitive to issues raised at your hearing.

Our providers were all directly affected by the transition of the new carrier and the addition of the test pilot contract with Healthcare Compare. The following are the most significant effects of the transition and ongoing relations with Aetna and Healthcare Compare.

*A complete stoppage of DME claims payments from Dec.15th, 1988, thru early February 1989. A period of 4-6 weeks where literally no payments were received. There was a continuing severe slowdown of claims processed for many months thereafter and did not reach an acceptable level until the summer.

*A significant increase in denials due to different interpretations of coverage criteria by Aetna than by the previous carrier, Prudential. Aetna failed to notify DME suppliers of these changes, thus a backlog of old claims awaiting the review and appeals process has resulted.

*Lack of adequate phone communication and informed staff at the carrier during the first several months. This increased typical transitional problems and created delays in claims processing.

*A concern for appropriate determinations of clean claims. We are required to use the reviews, appeals process as our only recourse if claims are deemed "unclean" and subsequently denied. This initial determination, if a claim is clean, cannot be used to avoid processing timetables.

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page 2

There are other ongoing concerns, including the developing of more stringent coverage guidelines by Healthcare Compare. Knowing the interpretation has never been an exact science, it is clear the carriers reliance on Healthcare Compare, has eliminated the subjective view on many claims.

Our industry has maintained a very high rate of accepting assignment. However; the events identified above have providers opting out of the program. This will have an impact on beneficiary access to quality services.

On behalf of the association I thank you for this opportunity to submit a statement for the record. We will continue to work with Aetna and Healthcare Compare to avoid any further damage to the Medicare program but need your continued support. We deeply appreciate your concern and your time to help with these very critical problems. I will be happy to answer any questions you or members of your committee may have.

Sincerely,

David Petsch
President (GAMES)
c/o Healthmaster 1-800-868-8806

ph/DP

cc: Congressman J. Roy Rowland